CASE CONCEPTUALIZATIONS BY MENTAL HEALTH AND MARRIAGE AND FAMILY COUNSELORS

By

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Based on lack of agreement about influence of professional training on clinical data interpretation, this study explored professional training, within accredited mental health counseling (MHC) and marriage and family counseling/therapy (MFC/T) preparation programs, for case conceptualization and initial treatment planning of master's and doctoral students. Student members of relevant listservs participated through a survey link.

Participants responded to a demographic questionnaire and three case simulations/vignettes. Each vignette described a situation MHCs or MFC/Ts likely would encounter in clinical practice. Respondents selected the likelihood for conceptualizing and/or planning therapeutic intervention in each of six therapeutic modalities. The weighted response scale ranged from extremely unlikely to extremely likely.

Relationships were investigated among response values and selected professional variables. Similarities and differences were found in how students conceptualize client concerns. Education level was associated with preferred conceptual style. Gender, program enrollment, primary type of clinical experience, professional association of the respondents and respondent's supervisor/mentor did not yield significant differences in response means. There were no relationships among each student's age and amount of supervised clinical practice and preferred case conceptualization. However, there were suggestions for what shapes trainees' conceptualization preferences. Patterns reflecting conceptual consistency were found among some professional variables and preferred client conceptualizations including between a respondent's identified academic program and conceptual dimension associated with particular specializations. Respondent's professional socialization also showed an association with preferred conceptual style. When response patterns were examined within each academic subgroup, a trend toward conceptual dimension consistency was found among master's- and doctoral-level MFC/T trainees and master's-level MHC students.

This study demonstrated that it is possible to clarify further associations among professional variables and conceptualization choices. However, additional research is necessary to understand fully factors contributing to students' conceptualization of clients' concerns and association among various training pedagogies and manners of conceptualization within MHC and MFC/T preparation programs.

CHAPTER 1
INTRODUCTION

A recent study by the World Health Organization, World Bank, and Harvard University (National Institute of Mental Health, 1996) revealed that mental health difficulties globally account for over 15% of all illnesses, which is more than all malignant diseases combined and second only to cardiovascular disease in incidence. Indeed, in any given year in the United States, an estimated one in five adults and one in ten children and adolescents experience a mental health difficulty severe enough to cause significant disruption to their normal functioning (National Institute of Mental Health [NIMH], 2001). While mental health difficulties differ in terms of severity, duration, etiology, prognosis, and appropriate treatment, they share the function of interfering with quality of life. Few people are untouched by the direct (e.g., treatment) and indirect (e.g., loss of workplace productivity, school problems, or financial instability) costs of mental health problems (NIMH , 2001).

The diverse nature and substantial prevalence of mental health issues has prompted many health and helping professionals to address the mental health problems that disrupt people's lives. In particular, mental health counseling and marriage and family therapy are two of the five primary disciplines recognized by the NIMH as qualified to do so. These disciplines intend specifically to assist persons affected directly and/or indirectly by mental health difficulties. However, the manner in which assistance is provided presumably differs by area of specialization, preferred conceptualization of

mental health problems, preferred approaches to treatment, and primary professional affiliation (American Association for Marriage and Family Therapy [AAMFT], 1999).

Distinguishing the nature of the differences among helping professions is difficult because of the lack of professional consensus about what is salient to differentiation, appropriate training to conduct sound inquiries, and confusion about the practitioner-researcher dichotomy (Vacc & Loesch, 2000). However, regardless of the difficulties, the nature of the helping professions is of key interest to consumers, healthcare organizations, businesses, the media, foundations, government, professional associations, students, practitioners, researchers, and educators (Doherty, 1997). For example, professional associations wish to enhance their legitimacy and professional status through research (Which services are best?); healthcare organizations want information that promotes cost-effective services (What type of therapy or intervention works best for whom and at what cost?); and the media are focused on providing information to consumers (What is new, different, and effective?).

Understanding the qualities of specialized areas of care and training is of particular interest to educators, graduate students, the research community, and university faculty. Counselor educators strive continuously to provide the best quality training for practitioners, researchers, and future educators in the field of counseling (Anderson & Rigazio-DiGilio, 1995; Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990; Fong, 1998; Wendorf, 1984). Thus, understanding if and how specialized training affects students is a key component of the counselor educator's job. Preparing students as thoroughly and responsibly as possible in endorsed standards of knowledge and competencies and in selected areas of counseling specialization is the goal. Quality of

preparation in turn impacts consumer quality of care, status of the counseling profession, potential employability of students, possibility of third party reimbursement from healthcare organizations, and availability of funding and support resources (Doherty, 1997).

This study is concerned specifically with the impact on counselor training. Given the notable difficulties associated with accurately addressing such a formidable task completely (Vacc & Loesch, 2000), this study focuses on a professionally agreed upon key aspect of training: a counselor trainee's ability to conceptualize client situations and problems (Anderson, 1992; Cummings et al., 1990; Duys & Hedstrom, 2000; Nelson & Neufeldt, 1998; Sluzki, 1981; Tucker & Pinsoff, 1984). Johnson and Brehms noted that the manner in which counselor trainees conceptualize client systems "greatly influences their understanding of human beings, as well as their chosen type and mode of treatment" (1991, p. 133). Specifically, this investigation seeks to clarify how counselor trainees' conceptualizations are influenced by their training within an area of specialization. The areas of specialization addressed here are mental health counseling (MHC) and marriage and family counseling/therapy (MFC/T). Although there are often variations in individual preparation practices for these specialties, only students trained within the parameters and standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for MHC or MFC/T specialization are addressed in this study.

Overview

As a relatively new profession, counseling emerged as a way to help people cope with rapidly changing societal and personal dynamics born of important events (e.g., the

Industrial Revolution and the social welfare reform movement) and personal influences (e.g., Freud's development of psychoanalytic theory, Beer's attention to the deplorable conditions of mental health care in the late 1800s, and Parsons' initiation of the vocational guidance movement). An examination of the history of counseling highlights its intimate linkage to changing client needs, social concerns, philosophical perspectives about the nature of human behavior, and governmental and societal interests. These interacting dynamics produced a profession with interdisciplinary roots, one unique from psychiatry, psychiatric nursing, social work, psychology, or guidance (Aubrey, 1983; Gladding, 2000; Nugent, 2000). Counseling is a process that emphasizes development, treatment, and prevention for people concerned with achieving and maintaining a healthy style of living across the lifespan (Vacc, 1990).

Just as the aforementioned interacting dynamics have shaped counseling as a unique discipline, so too have these dynamics shaped the preparation of professionals within the counseling profession. An historical review of the counselor preparation (education) literature reveals a maze-like developmental process. Eventually, however, preparation standards came to include fundamentals not only of counseling but also of training within an area of specialization such as MHC or MFC/T (Sexton, 1998a; Sweeney, 1995). Counselor educators are charged with the task of preparing professionals to facilitate clients' development in a manner that maintains accepted standards of practice. In particular, this criterion requires counselor trainees to have "current [within the last 10 years] knowledge of outcome research literature and the ability to skillfully apply the most current practices" (Sexton, 1998a, p. 3). To assist counselors to meet this standard, counselor educators continually raise questions about

what are the fundamental knowledge bases and skills for their students to be able to work effectively with individuals, children, families, couples, and diverse clientele in diverse settings and about the effectiveness of current educational practices (Everett, 1979; Sexton, 1998a, 1998b; Vacc & Loesch, 2000).

The professional counseling literature is rich with theoretical training models about how to prepare counselors to manage the conceptually complex variables of clients' concerns effectively. However, counselor education is only in the fledging stage of understanding and systematically inquiring into the effectiveness of these models, particularly as they relate to the primary practices of professional counselor educators: supervision, teaching, and clinical training (Avis & Sprenkle, 1990; Bradley & Fiorini, 1999; Cummings et al., 1990; Duys & Hedstrom, 2000; Goodyear & Bernard, 1998; Sexton, 1998).

Investigative overtures into counselor preparation have focused on a wide range of subjects. For example, Fong, Borders, Ethington, and Pitts (1997) investigated counselors' patterns of thought development and ability to process information. Goldberg (1974) studied the impact of counselors' levels of cognitive complexity on therapeutic interaction. Holloway and Wolleat (1980) demonstrated the direct relationship between counselors' conceptual complexity level and clarity of clinical hypothesis formulation. Borders, Fong, and Neimeyer (1986) speculated about the relationship of trainees' ego development to the client-counselor relationship. Cummings et al. (1990) studied the conceptualizations of novice and experienced counselors. Tucker and Pinsof (1984) conducted a comprehensive, empirical evaluation of a family training program. And finally, Hines (1996) investigated how well prepared graduates of an accredited AAMFT

program considered themselves to be. Through an investigation of the literature on marriage and family training, Kniskern and Gurman (1979) found outcome research on training and factors affecting training and family therapy outcomes to be minimal at best.

Examination of the research related to counselor training clearly reveals that much remains to be explored and/or substantiated (Fong et al., 1997; Kniskern & Gurman, 1979; Stoltenberg, McNeil, & Crethar, 1994; Vacc & Loesch, 2000). One aspect of counselor education that begs for further investigation, and is the subject of this study, is the difference in the respective ways various counselor trainees conceptualize clients' problems. As noted, the manner in which a counselor trainee views client concerns has a profound impact on the manner in which s/he conceptualizes all aspects of the therapeutic process (Sluzki, 1981). It follows that inquiry into the influence of training will contribute to the knowledge base of how to prepare counselors effectively to think deeply and adequately about client concerns and the counseling process (Cummings et al., 1990; Holloway & Wolleat, 1980; Huber & Carlson, 1994; Gladding, 2000; Johnson & Brehms, 1991; Sluzki, 1981; Stevens-Smith, Hinkle, & Stahmann, 1993; Stoltenberg, McNeil, & Delworth, 1998).

This study focuses on the relationship between conceptualization of client concerns and training within the specializations of MHC and MFC/T. Several factors influencing the counseling profession present unique challenges to this inquiry, including the limited existence of reflective and systemic evaluation of concepts guiding counselor education, overlapping epistemological issues of MHC and MFC/T, and multiple standards of training and accreditation (CACREP or COAMFTE), among others. Each of these issues is explored further in Chapter 2 of this study.

Theoretical Framework

While professionals agree that a solid foundation in theory is essential to counselor preparation, a diversity of opinions in regard to an appropriate theoretical basis exists amongst researchers and educators and therefore about key factors influencing trainees' development, acquisition, and application of new concepts (e.g., Blocher, 1983; Lipson, 1998; Vacc & Loesch, 2000). However, as a general orientation, Guzzetti and Hynd (1998) noted that clarity of understanding conceptual change dynamics is best attained through cross-disciplinary theoretical research, thereby creating a broader lens for understanding notable learning issues.

Each potentially applicable theory has its strengths and limitations, and each conceptual change perspective is only "one slant on reality" (Cooper, 1996, p.60). For example, multicultural conceptual change theory explores how the meaning of membership within a marginalized culture influences conceptual change. Similarly, Feminist theory analyzes gender interactions and various views of feminism in conjunction with conceptual change. From the perspective of domain literacy, an individual's conceptual change varies among differing domains in regard to interdependency among the variables of content knowledge, domain breadth, and motivation. Sociocultural theorists highlight the influence of student-teacher interactions and society's role in shaping new learning. From a social psychological perspective, conceptual change is subject to the influence of affective and cognitive variables. The postmodernists question traditional views of learning (Guzzetti & Hynd, 1998), and instead suggest that conceptual change results from an illumination of power, structures of interaction, and oppressive discourses that shape the way knowledge is "continually

constructed, situated, and negotiated" (p. 196) among contentious cultures. The salient point is that one theory should not be viewed as superior to another nor should its situational application marginalize other theoretical positions and approaches. However, it should provide the best analysis of a set of facts in relationship to one another (Dewey, 1986; Myers & Alvermann, 1998; Soltis, 1984).

Historically, conceptual learning research focused on cognitive factors (e.g., an individual's knowledge), with little attention being paid to other dynamics such as affect and nature. However, extensive study clearly demonstrated the limitations of a strong, rational-cognitive approach, thereby emphasizing the need for alternative approaches to understanding conceptual learning. Thus, for hundreds of years, researchers from various disciplines demonstrated and continued to disclose the value of alternative theoretical models (Sinatra & Dole, 1998). For example, through the use of selected vignettes, Guzzetti and Hynd (1998) presented multiple theoretical interpretations of the same data. Their work clearly demonstrates the value of multiple interpretations and selection of the best theoretical fit for a specific research situation.

The focus of this study, i.e., the influence of MFT/C and MHC training on trainees' conceptualization of client problems and treatment planning, is integrally related to the practice of counseling. Counseling practice, as well as the counselor's development, is commonly characterized as highly ambiguous, emotionally loaded, complex, contextual, and constructive in nature (Guzzetti & Hynd, 1998; Pace, 1988; Sluzki, 1981). The generally accepted complex and ambiguous nature of the counseling process has been compared to a circus performance in which a performer must simultaneously juggle bowling pins, blow bubbles, and spin a wheel atop his/her head

while bicycling an obstacle course of seemingly impossible to overcome obstacles (Johnson & Heppner, 1989). Given the nature of conceptual development, practice of counseling, and the importance of conceptualization in the counseling process (Sluzki, 1981), it can be safely assumed that the training of counselors is an equally complex task (Johnson & Heppner, 1989; Pace, 1988). Accordingly, the theoretical foundation of a study of such a process must account for the idiosyncratic and multifaceted nature of conceptual development and counseling practice (Guzzetti & Hynd, 1998; Pace, 1988).

Schema theory was selected as the foundation for this study. Schema theory does not explain all aspects of conceptual change; however, it does explain the key aspects, including the influence of social and natural factors upon cognitive development (Pace, 1988; Sinatra & Dole, 1998). The relevance of schema theory to this study is illustrated through its metatheoretical foundation and specific application to conceptual development, and therefore to the processes of counseling and counselor training.

Schema theory allows researchers to account for variables characteristic of the complex nature of conceptual development. Chinn (1998) and Pace (1988), among others, provided a strong argument for the use of schema theory in the study of conceptual development, particularly as related to counseling processes. Counselor preparation is a complex, dynamic, and often ambiguous process. However, schema theory serves well as a way to understand the process because it provides a framework for developing, evaluating, and synthesizing the complex dynamics that influence trainees' development of conceptualizations congruent with an area of specialization.

Statement of the Problem

Given counseling professionals' substantial support for the need for evidence of the impact of training, it might be assumed that the relationship between specialized training (e.g., MHC or MFC/T) and counselor trainees' conceptualization and treatment planning abilities has been thoroughly investigated. However, this is not the case. Several studies have investigated the clinical practice profiles of various licensed professionals (e.g., relationships between academic training and selected fields of clinical practice, differences among expert and novice counselors' ability to conceptualize client concerns effectively and subsequently plan treatment, and treatment outcome as related to professional practice approach and affiliation) (Beutler, Machado, & Neufeldt, 1994; Cummings et al., 1990; Doherty & Simmons, 1996; Knesper, Pagnucco, & Wheeler, 1985; Simmons & Doherty, 1995; 1998). However, there is little evidence about how specialized training influences the clinical tasks of case conceptualization and treatment planning among counselor trainees (Falvey, 2001; Vacc & Charkow, 1999).

The problem addressed in this study is that the difference in case conceptualization and initial treatment planning abilities of master's and doctoral students in CACREP-approved MHC and MFC/T programs is unknown. Also explored in this study are the influences of counselor trainees' age, gender, education level, primary professional affiliation, previous course work, current course enrollment, amount and type of practicum/internship experience, and the primary affiliation of their mentors/supervisors.

Need for the Study

"Comparison of identification along theoretical or conceptual systems is meaningful because it is therapists' orientation that greatly influences their understanding of human beings, as well as their chosen type and mode of treatment" (Johnson & Brehms, 1991, p.133). Epistemological distinctions, although not clearly defined, between MHC and MFC/T encompass alternative views of causality, symptom behavior, and methods of intervention. For example, a client's concern could be viewed as "What's wrong with Bob?" or "What purpose or meaning does Bob's behavior have within the relational system?" The point is not to determine which perspective is better, but rather how a person trained within a particular specialization and at a particular level of training understands client concerns, which will in turn dramatically shape the conditions for change within the client (Huber & Carlson, 1994; Presbury, McKee, & Moore, 1983; Sexton, 1994; Smith, Carlson, Stevens-Smith, & Dennison, 1995).

In the current environment of required therapeutic efficacy and cost effectiveness, providers of mental health services are monitoring closely the value of their work (Pinsof & Wynne, 1995; Simmons & Doherty, 1998). In order to survive in a health care system whose gatekeeper is managed care (Lawless, Ginter, & Kelly, 1999), practitioners of all professional affiliations and academic training backgrounds must continue to establish the value of their work. Because the future of many helping professionals remains unclear (Falvey, 2001; Pinsof & Wynne, 1995; Simmons & Doherty, 1998), it is important that the training of counselors be understood from the perspective of professional values relevant to a specialization (Falvey, 2001; Vacc & Charkow, 1999). Therefore, the benefits of this line of inquiry extend beyond facilitating counselor educators to better

prepare counselors. Indeed, information from this study is pertinent to students considering counseling careers, to employers selecting among job candidates, and to researchers, practitioners, and educators in generating resources (Vacc & Charkow, 1999).

Few studies have attempted to evaluate the quality of trainees' conceptual abilities in relationship to specialized preparation in CACREP-approved programs. More importantly here, no studies have been found that evaluated comparatively the conceptual capabilities and subsequent treatment planning of trainees in CACREP-approved programs for the specialized training of mental health counselors or marriage and family counselors/therapists. When conceptualization constructs and abilities have been examined, the research has tended to explore differences between novice and expert counselors (e.g., Borders, Fong-Beyette, & Cron, 1988; Etringer, Hillerbrand, & Claiborne, 1995; Hillerbrand & Claiborn, 1990; Kivlighan & Quigley, 1991; Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989), propose training and supervision modalities that are epistemologically consistent with specialization area (e.g., Britton, Rak, Cimini, & Shepherd, 1999; Epstein, Bishop, & Levin, 1978; Guntern, 1981), or investigate training from a within specialization perspective (e.g., Simmons & Doherty, 1998).

While these studies have shown relationships among various aspects of counselors' conceptual abilities and counseling, much remains unknown. For example, what is the association between trainees' conceptualizations of presenting problems and academic training? How are the goals of therapy and modalities of treatment, along with the assignment and frequency of diagnoses, associated with academic training? How are

a trainee's disciplinary association and other counselor development variables associated with conceptualization? And at what points in the counseling program do conceptual changes occur?

As noted, no studies have been found that focused on the conceptual abilities of trainees in differing programs and levels of training. Accordingly, along with the consistently significant attention by professionals addressing the importance of trainees' conceptual abilities (Nelson & Neufeldt, 1998), this study contributes to better understanding of counselor trainee conceptualization and treatment planning within an area of specialized counselor training and as influenced by relevant educational, experiential, and personal variables. This study also may be beneficial to students considering the counseling profession, employers, managed care professionals' understanding of professional distinctions and abilities to provide viable services, and researchers, educators, and practitioners seeking resources to support the advancement of the helping professions.

Purpose of the Study

The purpose of this study is to examine the relationship between academic training and conceptualization of clients' concerns among master's and doctoral-level students currently enrolled in CACREP-approved mental health counseling or marriage and family counseling/therapy preparation programs. This line of inquiry is important because conceptual differences imply differing views of causality, composition of client systems, and focus of therapeutic interaction among mental health service providers (Huber & Carlson, 1994; Sluzki, 1981; Worden, 1994). This study also will contribute to the available knowledge about current training procedures and counselor trainees'

conceptualizations in regard to area of specialization, level of training experience, and self-identified professional orientation preference (Murdock, Banta, Stromseth, Viene, & Brown, 1998; Prochaska, & Norcross, 1983).

It is important to note that this study will not examine the relative merits of either area of specialization, nor does it address the longstanding debate about whether each specialization area is a freestanding profession or a specialization within a broader profession. The demonstrated efficacy of both specializations is acknowledged. mental health counseling and marriage and family counseling/therapy are viewed here within the framework established by CACREP, a perspective not intended to support either view of the profession-specialization debate.

Null Hypotheses

The following hypotheses will be tested in this study:

1. There is no difference in trainees' conceptualization ratings based on a trainee's age category.
2. There is no relationship between ratings of conceptualization and the number of practica and/or internships trainees have completed.
3. There is no difference in trainees' conceptualization ratings based on gender.
4. There is no difference in trainees' conceptualization ratings based on academic major (i.e., professional specialization).
5. There is no difference in trainees' conceptualization ratings based on academic program level.
6. There is no difference in trainees' conceptualization ratings based on their professional affiliation.
7. There is no difference in trainees' conceptualization ratings based on type of program accreditation.
8. There is no difference in trainees' conceptualization ratings based on primary type of practica and/or internship experience.

9. There is no difference in trainees' conceptualization ratings based on professional orientation of their respective primary supervisor/educator.

Definition of Terms

The following terms are defined here as they pertain to this inquiry.

Professional counselors are uniquely trained to focus on and find effective solutions for the normal developmental conflicts of clients and/or to provide remediation, prevention, or educational counseling services (Gladding, 2000; Seiler, 1990). Professional counselors are typically trained in one or more areas of specialization, including but not limited to mental health and marriage and family counseling/therapy. They possess a minimum of a master's-level degree in counseling and are certified at the national level and/or licensed, credentialed, or certified in accordance with state law (Nugent, 2000; Vacc & Loesch, 2000).

Counselor trainee is a person currently enrolled in a master's or doctoral-level counselor preparation (training) program, with a specialization in either MHC or MFC/T.

Mental health counseling trainee is a person currently enrolled in a CACREP-approved program with a specialization in MHC.

Marriage and family counseling/therapy trainee is an individual currently enrolled in a CACREP-approved program with a specialization in marriage and family counseling/therapy.

Standards of preparation are professionally identified guidelines that ensure, through educational requirements and supervised experiences, that counselor trainees receive the minimum knowledge and skills necessary to perform effectively in the subsequent counseling work environment (Sweeney, 1995).

Specialty standards identify minimum levels of knowledge, skill, and supervised practice necessary to represent a designated specialty in the counseling profession (Seiler, 1990).

Accreditation "is awarded to professional programs within institutions or to occupational schools offering specific training skills and knowledge. Specialized accrediting bodies define standards of excellence in educational training programs for recognized professions. In addition to CACREP, other well-known specialized accrediting agencies include the American Bar Association, the American Medical Association, and the American Psychological Association" (CACREP, 2002, http://www.counseling.org/cacrep/student.htm) and the Commission on Accreditation for Marriage and Family Therapy Education.

Council for the Accreditation of Counseling and Related Educational Programs (CACREP) is one of several counselor preparation program accrediting bodies. The CACREP orientation views effective counselor preparation to include educational and supervised training experiences in specified core curriculum areas and at least one area of specialization (e.g., MHC or MFC/T) (Vacc & Loesch, 2000).

Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is an accrediting body for the preparation of marriage and family therapists. The standards of MFT preparation focus on understanding the concerns of clients from a contextual basis, to explore patterns of interaction, roles, rules, beliefs, life cycle development, and social, cultural, and familial influences (AAMFT, 1999).

Counseling specialty is a term that refers to a specific area of counseling in which a distinct body of knowledge and expertise has been identified (Remley, 1995).

Mental health counseling (MHC) is a counseling specialty that emphasizes services to individuals, groups, or families in community, business, and private practice settings. Counseling services include prevention and treatment of client problems, as well as consultation services, vocational assistance, and provision of individual and/or family counseling services (Vacc & Loesch, 2000).

Marriage and family counseling/therapy (MFC/T) is a counseling specialty that emphasizes prevention of family/couple problems and intervention to help families/couples alleviate existing obstacles effectively to promote healthy growth and development of the family and/or couple unit. This focus, along with a systemic orientation, is presumed to be critical to effective counseling (Gladding, 2000; Nugent, 2000; Vacc & Loesch, 2000).

Conceptual system is "a schema that provides the basis by which the individual relates to the environmental [therapeutic situation] events [one] experiences" (Harvey, Hunt, & Schroder, 1961, p. 245).

Conceptualization is the manner in which a counselor trainee organizes the multifaceted and variable concerns of clients (Harvey et al., 1961). It is intimately linked to treatment planning (Falvey, 2001).

Conceptual development is a process through which counselor trainees become able to formulate relevant clinical hypotheses, demonstrate increased ability to describe clients in interactive terms, and provide more prudent conceptualizations of specific counseling situations (Fong et al., 1997).

Treatment planning is a process in which counseling goals and objectives are developed and progress is monitored. Treatment plans are designed to meet the assessed

needs of clients specifically (Johnson, 1997). The particular plan selected and followed is strongly connected to the counselor trainee's conceptualization of clients' concerns (Falvey, 2001).

Training, for the purpose of this study, encompasses all aspects of counselor preparation including the dissemination of knowledge, clinical supervision, and curriculum development (Anderson & Rigazio-DiGilio, 1995).

Overview of the Remainder of the Study

Chapter 1 provided an overview of this study, including attention to the problem upon which this study is focused. Chapter 2 provides a review of literature pertinent to this study, including factors influential to the counseling profession and how counseling is conceptualized and practiced. The research methodology is presented in Chapter 3 and the results are presented in Chapter 4. Discussion of the research and its implications are presented in Chapter 5.

CHAPTER 2
REVIEW OF THE LITERATURE

This chapter presents a review of relevant literature and seeks to clarify how counselor trainees' conceptualizations are influenced by their training in counseling specializations represented by mental health counseling (MHC) and marriage and family therapy/counseling (MFC/T). Also included is a summary of the purpose and functions of the methodology and instrumentation employed.

Counselor Education

The profession of counseling, given life from the guidance movement and in opposition to traditional psychotherapy, is comprehensive and continually evolving (Gladding, 2000; Hollis, 1997). The profession's developmental history thus reflects a dynamic interaction between the needs of clients and society and how counseling professionals work to apply mental health, psychological, or human development principles effectively and ethically. These principles are applied through "cognitive, affective, behavioral or systemic interventions, [or] strategies that address wellness, personal growth, or career development, as well as pathology" (ACA, 2002, http://www.counseling.org/consumers_media/servingallpeople.htm). Effective preparation of counseling professionals demands "quality education and supervision in all work settings" (ACES, 2002, http://www.siu.edu/~epse1/aces/). The types of courses,

settings in which courses are implemented, amount of client contact, and type and amount of supervision are some of the critical components of counselor education.

Professional accreditation plays a central role in the counselor education process (ACES, 2002; Hollis, 1997; Stevens-Smith, Hinkle, & Stahmann, 1993) and two accrediting associations are of particular relevance here. These two nationally recognized entities establish criteria and procedures to ensure the satisfactory preparation of counseling professionals: the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

Standards of Training

Designating and continually evaluating the minimum proficiency levels for master's, doctoral, and post-degree clinical training programs in marriage and family therapy is the purpose of COAMFTE, which gained official recognition in 1978 by the U.S. Department of Education (COAMFTE, 1994). While CACREP and COAMFTE share the goal of assuring adequate preparation of professional counselors, they differ in philosophy and approach.

In 1949, the Commission on Accreditation for Marriage and Family Education (COAMFTE) developed the first training standards for professionals seeking entry into the field of marriage and family counseling/therapy (Touliatos & Lindholm, 1992). For almost four decades, COAMFTE standards represented the exclusive path by which marriage and family counselors/therapists could obtain standardized training and establish a professional identity within the family of helping professionals.

COAMFTE views marriage and family therapy as unique among helping professions (e.g., social work, psychology, or counseling), a philosophy reflected in COAMFTE-accredited programs (Stevens-Smith et al., 1993) as well as by the title used by graduates to identify themselves in their work. Specifically, the preferred identity of MFC/T's trained within COAMFTE programs is marriage and family *therapist*; these MFC/T's are trained from an interactional and systemic perspective (Remley, 1992).

Established in 1981 by the American Counseling Association, CACREP's accreditation standards encompass mental health counseling as well as marriage and family counseling at the master's degree level, and counselor education at the doctoral level (CACREP, 2001; Hollis, 1997). CACREP is the only accrediting body that addresses counseling needs at the master's degree level and in more than one type of counseling specialty (Sweeney, 1992). CACREP represents an alternative philosophical stance and path of standardized training for MFC/Ts; it views marriage and family counseling as a discipline within counseling (Remley, 1992). Consequently, CACREP accredited programs demand comprehensive training (e.g., foundations in career and group counseling) prior to and/or simultaneously with specialized training in marriage and family counseling (Stevens-Smith et al., 1993). Their preferred identity is as a marriage and family *counselor*.

Accredited programs vary in scope and curriculum content, as well as in required clinical experiences. The significance of the title distinctions influences the methodology (e.g., sampling) of this study and has implications for evaluation of findings and future research. The distinctions derived from the differing philosophies do not bring into question the competency of counselors/therapists trained in either CACREP or

COAMFTE-approved programs. Competency is not based on whether MFC/T is defined as a discipline unto itself or a specialty within the field of counseling. Rather, it is based on course work and practicum and internship sufficiency, and the experience and competence of faculty providing training. Therefore, both CACREP and COAMFTE are prepared to promote training of competent MFC/Ts (Stevens-Smith et al., 1993).

CACREP: Role in counselor preparation

CACREP, the largest accreditation organization for counselor training, accredits specialties, not general counseling programs. Consistent with the philosophical stance of ACA, CACREP calls first for the preparation of individuals as counselors and secondly as counseling specialists. The CACREP standards are designed to ensure that students/trainees develop a professional counselor identity, master the knowledge and skills necessary to practice effectively, and possess at least the minimum competence for careers in counseling practice, education, and/or research. The standards also ensure development of an understanding and commitment to lifelong continuing education and review of professional standards necessary to promote effective professionals in an ever-changing world (CACREP, 2001; Steinhauser & Bradley, 1983).

At the master's level, CACREP accredits five areas of specialization, including MHC and MFC/T. As of June 06, 2002, CACREP reported 27 MHC-accredited programs and 26 MHC/T-accredited programs. For all specializations, trainees are required to possess demonstrated knowledge in eight common core areas and to complete supervised practica and internships satisfactorily. The required eight core elements include study in human growth and development, social and cultural foundations, helping relationships, group work, career and lifestyle development, appraisal, professional orientation, and

research. Masters-level training consists of at least 60 semester credit hours, within which trainees complete the required elements of the core curriculum and studies within their selected area of specialization (CACREP, 2001; Sweeney, 1995).

An important caveat of this study is that while CACREP standards generally describe programs in MHC and MFC/T, they do not define what constitutes these specialties. The CACREP specialty standards for MHC and MFC/T require similar curricular experiences, yet there is uniqueness to each area of specialization, including foundations, contextual dimensions, clinical experiences, and essential skills (CACREP, 2001).

At the doctoral level, CACREP accredits counselor education and supervision programs; 43 programs were accredited as of mid-2002. A primary obligation of doctoral programs is to advance "the knowledge base of the counseling profession in a climate of scholarly inquiry" (CACREP, 2001; http://www.counseling.org/cacrep/2001standards700.htm). Doctoral-level trainees must meet all entry/master's-level requirements, plus an additional 36-semester hours of graduate-level study. These latter studies are designed to prepare them to work as advanced (i.e., more competent) practitioners in clinical and academic settings, to be leaders of the profession, to generate new knowledge through research, and to work as counselor educators and supervisors. "It is expected that doctoral students will have experiences that are designed to develop an area of professional counseling expertise" (e.g., MHC, MFC/T) (CACREP, 2001, http://www.counseling.org/cacrep/2001standards700.htm).

COAMFTE: Role in counselor education

COAMFTE, specializing in the accreditation of marriage and family programs, seeks to foster quality assurance and continued program improvement to graduate level training programs and post-degree clinical training centers. In cooperation with state licensing and certification boards and the Association of Marital and Family Regulatory Boards (AMFTRB), COAMFTE operates autonomously within AAMFT, its parent organization. As such, COAMFTE is concerned with ensuring that accredited programs are providing professional caliber training (COAMFTE, 2002a; Smith & Nichols, 1979; Wendorf, 1984). COAMFTE aims to provide optimal objectivity in the process of program accreditation while facilitating maximum input from professionals and the public in what constitutes the continually evolving minimum level of training for competent MFTs (COAMFTE, 2002a, Smith & Nichols, 1979).

At the master's level, COAMFTE standards are designed to meet minimum level requirements for graduates to enter and effectively engage in clinical practice. Trainees thus are provided a foundation in professional development and basic clinical and didactic skills. At the doctoral level, the curriculum is focused on advanced MFT theory, research, and supervision. This level of training is designed to prepare trainees adequately for work in academia, research, and/or advanced clinical practice and supervision. Post-graduate degree clinical institutions provide further clinical training for trainees who have achieved a master's or doctoral degree. It is not unusual for this type of training to allow trainees to focus on clinical work with a particular population and/or within a particular modality of treatment (COAMFTE, 2002a).

As of mid-2002, 81 programs, in 37 states and four Canadian provinces, were accredited by COAMFTE. Of these, 50 were master's level, 15 were doctoral level, and 16 were post-graduate training centers. Eleven other programs had achieved candidacy status, with eight at the master's level and three at the doctoral level. States and provinces not having at least one accredited MFT program include Alaska, Arizona, Delaware, Hawaii, Idaho, Maine, Montana, Nevada, New Mexico, Vermont, West Virginia, Wyoming, and the Canadian province of British Columbia (COAMFTE, 2002b).

COAMFTE standards evolved and continue to develop in accordance with the unique needs of the profession of marriage and family therapy. The standards are based on a respect and understanding of diversity and non-discrimination from a relational view of life. Graduates of COAMFTE accredited programs are presumed to be qualified to "diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems, [delivering] professional services to individuals, couples and families for the purpose of treating such diagnosed nervous and mental disorders" (COAMFTE, 2002a, http://www.aamft.org/about/coamfte/standards_of_accreditation.htm).

Within AAMFT's philosophical stance, COAMFTE standards reflect two distinctive features. First, COAMFTE specifies that all training be relational, contextual-connected, and culturally sensitive regardless of treatment modality (e.g., individual or multiple person contact), diagnostic environment (e.g., traditional DSM IV TR or relational), and whether a client's concerns are presented as being directly related to marriage and family issues. Second, the standards emphasize relational, direct-client-contact experience (COAMFT, 2002a; Smith & Nichols, 1979).

CACREP and COAMFTE Compared

The differing philosophical orientations of COAMFTE and CACREP relative to training of counseling professionals are reflected through differences in training standards and curriculum that contribute to the respective professional identities. Through an analysis of the current standards established by COAMFTE (Version 10.1) and CACREP (2001 standards) and the work of Stevens-Smith and colleagues (1993), the following are comparative observations of COAMFTE and CACREP programs.

At the master's level:

- CACREP requires 60 semester-hours while COAMFTE requires 45 semester-hours. CACREP's additional hours reflect primarily further training in individual counseling, psychotherapy, career counseling, human growth and development, and group dynamics.

- COAMFTE holds that all educational experiences will be based on a "relational view of life in which an understanding and respect for diversity and non-discrimination are fundamentally addressed, practiced, and valued. Based on this view, marriage and family therapy is a professional orientation toward life and is applicable to a wide variety of circumstances, including individual, couple, family, group, and community problems" (COAMFTE, 2002a, http://www.aamft.org/about/coamfte/standards_of_accreditation.htm). CACREP attends to a systems/relational understanding of peoples' lives primarily within educational experiences for trainees specializing in marriage and family counseling. The eight core areas of counselor training in CACREP are not dictated to reflect a relational perspective of peoples' lives.

- CACREP requires fewer client face-to-face (e.g., counselor/therapist and client) contact hours than COAMFTE. Between the practica (40 hours) and internships (240 hours), CACREP requires a total of 280 direct-client-contact hours, including individual and group counseling experiences. CACREP classifies the 240 direct-client-contact internship hours as the point at which trainees are to work primarily with couple and family units. COAMFTE requires 400 direct client contact hours, with at least 250 of these hours occurring with couples or families present in the therapy room.

- Training in assessment, diagnosis, and treatment are required by COAMFTE and CACREP. Neither body endorses a pathology-based perspective of mental health.

- Program faculty must have an earned doctoral degree in counselor education or a closely related field and experience (e.g., publication or clinical practice) relevant to the specialization of marriage and family counseling in order to meet qualifications within CACREP accredited programs. COAMFTE faculty must meet clinical practice standards, as established by the American Association of Marriage and Family Therapy (AAMFT), and be actively engaged in clinical practice and scholarship. CACREP and COAMFTE faculty respectfully identify with their professions through membership and involvement in professional organizations, ACA and AAMFT respectively.

- COAMFTE programs must have at least two AAMFT Approved Supervisors and a third faculty member who is a Supervisor in Training (SIT). CACREP programs require clinical instruction faculty/supervisors to have a doctoral degree and/or appropriate marriage and family clinical preparation.

At the doctoral level:

- CACREP and COAMFTE assume that doctoral trainees have completed entry-level requirements within their respective accrediting guidelines. Should this not be the case, students must attend to entry-level requirements prior to the doctoral curriculum.

- COAMFTE requires an additional 42 semester hours of didactic experience. CACREP requires an additional 36 semester hours of didactic instruction.

- COAMFTE requires a doctoral trainee's dissertation to be in the field of MFT. CACREP makes no such specification.

- Both accrediting body guidelines are designed to promote and refine advanced counseling skills, with trainees developing professional counseling expertise (West, Bubenzer, Brooks, & Hackney, 1995). CACREP specifies that an area (e.g., MFC/T) of counseling expertise be conceptually linked to teaching and supervision. COAMFTE makes no such direct specification.

- COAMFTE requires an additional 600 direct client contact hours above entry-level standards and a minimum nine-month, supervised internship emphasizing relationally focused practice and/or research. A total of 600 clock hours, not limited to face-to-face counseling, are allotted to CACREP's required internship experiences. These hours include supervised experiences in teaching, supervision, and clinical settings. Allocation of the CACREP required clock hours, which are appropriate to a trainee's career goals, is determined by the doctoral trainee and his/her advisor(s).

Counselor educators are dedicated to educating trainees as comprehensively and responsibly as possible (Gerber, 2001; Hitchcock, 1986; Nelson & Neufeldt, 1998;

Sexton, 1998b). Standards, designed in accordance with the needs of a dynamic society, guide counselor educators in this task (Wilcoxon, 1990). As such, an established, yet fluid, set of knowledge content areas and competencies are vital to the preparation of competent counselors (Nelson et al., 1998). The ultimate reflection of these competencies is the trainee's ability to understand and address client concerns adequately and accurately.

Importance of Conceptualization to Counselor Development

The value of conceptual abilities lies in it being a means of organizing client information, providing a common language, and having a framework from which treatment plans may be guided, implemented, and evaluated (Beavers, 1981). Counseling trainees must have a theoretically sound and justifiable reason for making assessments and plans (Hitchcock, 1986). Nelson and Neufeldt's (1998) critical examination in counselor education pedagogy revealed that the development of trainees' abilities to understand and address client concerns (also referred to as conceptualization) to be a highly valued component of training.

A chronological review of the development of counseling, and subsequently the manner in which trainees are prepared to work with clients, reveals an evolving philosophical and theoretical progression of choices that correspond to the social, political, and health-related needs of a dynamic society (Gerber, 2001; Piercy, Sprenkle, Wetchler, & Associates, 1996). For example, in the 1960s, the "guidance" view of counseling, and in particular the work of E.G. Williamson (1950), yielded a "directive counseling" approach to conceptualizing a client's concerns. That is, clients were viewed through a lens of deficiency; clients lacked some knowledge, ability, or insight in which

the counselor was expert. Counselors who learned and utilized this perspective identified a client deficiency and "directed" (i.e., gave information and/or instruction) to the client to solve a particular insufficiency in a particular way.

An alternative view of counseling, and therefore of conceptualizing an individual's problems, was the work of Carl Rogers (Zimring & Raskin, 1992). Rogers rejected directive approaches to individual therapy, and his counseling approach became known as "nondirective counseling" (Corey, 1996). In it, counselors were not all knowing or even in possession of the solution to an individual's problem. Indeed, clients are viewed as possessing the basic resources to solve whatever the presenting concern might be. What clients needed from a therapist/counselor was an atmosphere of "unconditional positive regard" in which a client experienced acceptance (not judgment) from the counselor in regard to whatever feelings the client was experiencing. A counselor working from this perspective viewed his/her work as the process of clarifying a client's feelings, thereby facilitating a client's insight and subsequent resolution of a problem.

These examples are illustrative of the many ways in which counseling/therapy has been, and continues to be, evolving in relation to various forms of viewing the human condition. Indeed, many shifts in thinking and theoretical paradigms have influenced the field of counseling and the manner in which counselors/therapists conceptualize client concerns (Corey, 1996). The analytic paradigm, from which the previous examples were either derived or a reaction to, is broadly based on personality reconstruction, insight, and unconscious motivation. For example, the philosophical foundations of existentialism focus on the meaning of being "fully human" (p. 8), giving particular attention to the

concepts of freedom, choice, responsibility, autonomy, purpose, and the anxiety created by the need to find meaning in a world deficient in inherent meaning. The humanistic paradigm, which shares many of the philosophical underpinnings of existentialism, holds a less anxiety-based view of finding meaning in life. In essence, humanists believe that, if provided with the appropriate conditions, a person will naturally be empowered to develop his/her capacities and find meaning in life. Accordingly, a counselor/therapist would not actively intervene or give direction in a client's life. Instead, the counselor's/therapist's work would be to create an authentic relationship with the client that would empower the client's natural capacities toward positive growth.

In yet another shift in thinking, some counseling approaches emphasized action with specific behaviors. An action orientation in its infancy focused on and demonstrated that Behavioral conditioning approaches to solving client problems are sometimes considered viable alternatives to insight-oriented approaches. An action orientation represents a fundamental departure from an analytic conceptualization of client concerns and the process of therapeutic work.

A systemic paradigm, born of Bateson's studies in cybernetics (Piercy et al., 1996), represented another conceptual shift that challenged the aforementioned frameworks for understanding client concerns, the origins of the concerns, and approach to treatment. In a systemic view, an individual is best understood as being intimately connected to larger systems (e.g., family or peers). Thus it requires the larger context of an individual's life to be addressed in order to provide counseling/therapy adequately and accurately (Piercy et al., 1996).

Each of these theoretical paradigms can form the foundation of counseling. Yet there are many variations (e.g., theories of counseling) born of each paradigm and/or reconstituted by virtue of the introduction of a new paradigmatic shift; they generally vary in the way an individual is viewed in relationship to the presenting problem. Simplistically, the representative paradigms focus on resolving the problem by change occurring within an individual or changing the system to address the concerns of the individual (Corey, 1996; Smith, Carlson, Stevens-Smith, & Dennison, 1995). Each of these broad paradigms offers ways to conceptualize client concerns and an approach to treatment (Nichols & Schwartz, 1998).

Case conceptualization, also known as clinical hypothesis formation, is substantially spotlighted in the counseling literature. The literature reflects a common manner of applying the paradigms and addressing trainees' abilities to evaluate client concerns appropriately and accurately and to make sound clinical decisions through the implementation of various counseling models. Schwitzer (1996) provided a sequential clinical decision-making model to facilitate trainees' abilities to conceptualize effectively. Beavers (1981) also designed a classification system for family counselors/therapists derived from an assessment of a family's operating style and competence in task performance. Matching a particular theory and applicable intervention to a specific client concern as a method of trainee case conceptualization development thus has been proposed in multiple forms and by many different professionals (e.g., Breulin, Schwartz, & Mac Kune-Karrer, 1997; Hutchins, 1979; Murdock, 1991; Preston, 1998).

Given society's demand for effective counseling strategies, the development of numerous conceptual models is not surprising (Mueller, Dupuy, & Hutchins, 1995). Counselor educators give considerable attention to enhancing the effectiveness of trainees' capacity to reason and to make theoretically sound clinical hypotheses and treatment/intervention decisions (Gerber, 2001; Nelson & Neufeldt, 1998). In light of the profound importance conceptualization plays in the work of MHCs and MFC/Ts, it stands to reason that a growing interest in understanding the conceptualization characteristics of professionals' therapeutic interactions with clients would be evident in the professional literature. Indeed, a growing interest can be found, particularly as it relates to conceptual skill level differentiation between novice and expert counselors (e.g., Goldberg, 1974; Holloway & Wolleat, 1980). Also present in the literature are conceptualization distinctions among the various nationally recognized helping professions (e.g., psychologists, marriage and family therapists, and social workers). A budding interest is evident in the area of trainee conceptualization development; however, there is a paucity of evidence on the conceptualization characteristics of students/trainees as they relate to their selected areas of specialized counselor training.

As noted, CACREP does not define areas of specialization other than by specific standards of training. Their standards also do not attest to how an area of specialization impacts the manner in which a trainee will conceptualize client concerns. Yet it is assumed that trainees will develop particular ways of working with clients based on the perspectives valued within a particular specialization. An understanding of the origins of these dilemmas, within the larger context of counseling, provides a foundation for

illuminating the distinct qualities that both connect and distinguish the conceptualization perspectives and treatment planning activities of MHCs and MFC/Ts.

Key Conceptual Issues in MHC and MFC/T

Counseling has many definitions depending on the context in which it is applied. For some, the answer to the question, "what is counseling?" is readily apparent and even axiomatic; it is a process in which a professionally trained counselor/therapist engages in a relationship with at least one other person to help resolve a problem. To others, the meaning is not so self-evident. For example, counseling, when applied to society's laws and regulations, has legal connotations. "Financial counseling" is often used to convey exchange assistance to address or enhance a person's fiscal and security base. Webster's dictionary defines counseling as "advice: opinion or instruction regarding the judgment or conduct of another" (Costello, 1995, p.310). Similarly, the application of counseling within the context of managing personnel commonly relates to disciplinary processes. Yet while counseling falls into a category of "semantic promiscuity" (Clare & Thompson, 1981), counseling within the context of psychotherapy practice, and regardless of the specialty or discipline, is concerned with addressing clients' personal and emotional concerns in a climate of confidentiality (Feltham, 1995).

Feltman (1995) noted that the history of counseling (e.g., separating counseling from the notion of advice-giving), semantics (e.g., inherent difficulty in defining concepts), and professionalization (e.g., need for professions to create boundaries that ensure a place for each profession within the overall professional community) dramatically influence the meaning of counseling. In light of these integrally connected factors, a single common definition of counseling may be impossible to achieve.

ACA, the organization from which the CACREP standards evolved and continue to be evaluated, does not define counseling. It follows that CACREP does not specifically define any of its counseling specialties. The fact that these professionals cannot come to a consensus about what specialists (e.g., MHCs and MFC/Ts) do and how they differ is not surprising. Reference to ACA's philosophy about counseling and the CACREP standards readily suggests that counselors trained in an area of specialization will be trained in many similar capacities. However, MHCs and MFC/Ts also will receive distinct training experiences. This state of affairs creates an interesting challenge particularly salient to this study. However, three specific areas, derived from professional practice, research, and education of MHCs and MFC/Ts, constitute a basis for evaluating the conceptualization qualities of trainees prepared in MHC and MFC/T programs.

Similarities Between the Disciplines

While counseling has not been defined, ACA has endorsed a definition of the practice of counseling (Gladding, 2000). MHCs and MFC/Ts thus are a part of the counseling profession in which trainees complete a required course of study, adhere to ethical codes that protect the public interest, and are actively involved in addressing various concerns that clients encounter. MHCs and MFC/Ts are able to address a wide range of client concerns, including prevention, normal growth and development, and remediation of mental disorders. Trainees work with individuals, groups, couples, and families and base their work on various theories. Beyond MHC's and MFC/T's primary role in direct client services, they also are prepared to engage in various capacities (e.g., consultation, diagnostic evaluation, education, and crisis intervention) that meet the needs of a diverse society (Gladding 2000; Nugent, 2000).

MHC and MFC/T share more than the aforementioned general principles; however, in 1991, Horne and Passmore noted that a major similarity between MHC and MFC/T centers on theory. Trainees in MHC and MFC/T all are provided with broad philosophical and psychological backgrounds. Theories employed in MHC also are employed in MFC/T, including Adlerian theory, reality therapies, Gestalt theory, and behavioral approaches, among others. Training in multiple theoretical approaches allows trainees to evaluate the worth of a particular approach independently (Nugent, 2000).

MHC and MFC/T also share a number of basic assumptions. Both specialties

- focus on problems between the environment and the individual;
- are developmental; and
- acknowledge the importance and influence of family in an individual's life (Gladding, 2000).

However, although MHC and MFC/T share many foundation elements, the philosophy within which the respectively trained student is prepared to apply the assumptions is globally different (Beavers, 1981; Gladding, 2000; Huber, & Carlson, 1994; Hurvitz & Strauss, 1991; Nugent, 2000; Smith et al., 1995).

Differences Between the Disciplines

Theoretically, MFC/T trainees must learn additional theories (e.g., structural, strategic, and solution-focused) as well as new applications of shared theories. For example, shared assumptions are conceptualized differently based on the manner in which MHCs and MFC/Ts view all aspects of human behavior. These two counseling specializations tend to differ on three levels. The key dimensions, referring to MHC and MFC/T, include movement from individual to system's dynamics, a shift from linear to a circular view of causality, and a focus on content versus process dynamics.

Conceptualization is significantly impacted when trainees view clients' concerns in these alternative ways (Huber & Carlson, 1994; Worden, 1994).

Individual versus Systems Dynamics

Individual dynamics focus on the "identified client's" experiences, with particular attention given to intrapersonal experiences (i.e., conscious and unconscious thought). An MHC's theoretical foundation is embedded in individual dynamics. The primary goal of this perspective is to bring about therapeutic change from within an individual (Huber & Carlson, 1994; Worden, 1994). A symptom is viewed as expression of a problem and also as an ineffective way to resolve inner conflict (Beavers, 1981). In other words, a trainee employing this orientation conceptualizes an "identified client's" concerns with an idea that resolution falls primarily within the landscape of altering a cognitive, affective, and/or behavioral aspect of a client's personality. An individual perspective does not ignore social interaction and development; indeed, an individually oriented trainee is interested in knowing about a client's life experiences and the quality of his/her relationships. Nonetheless, the conceptual focus remains on exploring the manner in which a person responds to internal demands. Subsequently, treatment plans are designed to promote change within the personality of a presenting client (Corey, 1996; Huber & Carlson, 1994; Smith et al., 1995; Worden, 1994).

Systems dynamics, the theoretical foundation for MFC/T, creates a different lens through which trainees conceptualize clinical concerns and engage in the process of therapeutic change (Sexton, 1994). A symptom is viewed as a reflection of and an attempt to resolve relational conflict. A systemic orientation does not ignore the concept that symptoms also may be a reflection of internal conflict that a person is attempting to

resolve. However, systemic trainees are "concerned with the interactional effects of symptomatic behaviors rather individual motivations or intentions" (p.250). Thus, a trainee working from a systemic lens does not conceptualize an individual's behavior in isolation, but develops an understanding of a client's concerns as being integrally related to a broader context. Systemic thinking prompts a student/trainee to be concerned with repeated patterns of interpersonal interactions that ultimately organize as rules and roles to establish consistency within a client's relational systems (Hoffman, 1981; Sexton, 1994). Essentially, this perspective is guided by the principle that the whole is greater than the sum of its parts (Worden, 1994). Because of this interdependent view of human behavior, intervention/treatment plans aim to facilitate change in a larger context or in specific intrapersonal relationships. Therefore, change applied to any part of an individual's relational systems will impact other parts of the immediate system and beyond, which will consequentially address an individual's symptoms (Beavers, 1981; Corey, 1996; Huber & Carlson, 1994; Smith et al., 1995; Worden, 1994).

Linear versus Circular Causality

A shift from an individual to a systems perspective not only changes the nature of a problem but also influences the notion of causality explored in programs specializing in the education and training of MHCs or MFC/Ts. Generally, individual points of view support the notion of linear causality, while a systemic perspective yields a circular notion of causality. Like the sequential fall of dominoes placed in a straight line, linear causality follows that event A causes event B and so on. As such, the focus of counseling is on the "cause" of the problem. Linear causality suggests that a person possesses some psychological trait that is causing the problem. Therefore, treatment is designed to change

some part of an individual's personality that is creating the problem (Corey, 1996; Huber & Carlson, 1994; Strong & Claiborn, 1982; Worden, 1994). This type of approach also is known as first-order change (Watzlawick, Weakland, & Fisch, 1974).

In first-order change, a trainee identifies the most logical "cause" of a problem and subsequently targets the "cause" in an intervention plan (Watzlawick et al., 1974). Again, this view of causality and approach to treatment is a common element of MHC practice (Corey, 1996; Huber & Carlson, 1994; Strong & Claiborn, 1982; Worden, 1994).

An alternative to linear causality is the notion of circular causality, which is often referred to as second-order change by systemically oriented trainees (Watzlawick et al., 1974; Worden, 1994). Circular causality views a client's behavior as reactionary to other members of a client's system (e.g., family) and a client's behavior simultaneously influences other members' behaviors. In the traditional language of MFC/T, this process of understanding the cause of behavior is often referred to as feedback loops, i.e., naturally occurring processes within all systems. This process guarantees that a particular system maintains a steady state and/or progresses toward a particular goal. Feedback loops may be negative or positive, depending on the degree to which a particular system reduces deviation from the status quo or encourages change (Becvar & Becvar, 1996; Nichols & Schwartz, 1998).

When the concept of circular causality is applied to a client, a trainee will focus on several key features of the client's situation. He/she attempts to discern the "rules" of the client's influencing systems that govern the range of acceptable behavior. Second, the tools that are used within a client's systemic world to enforce the spoken and unspoken rules of behavior are sought. In addition, a circular view of causality is concerned with

the patterns of interaction surrounding a client's problem. For example, how does a family react to a problem? What is the sequence of a family's reactions? What are the existing feedback loops around a client's concern? This principle, when applied to counseling/therapy, prompts the trainee to evaluate how systems, of which a client is an intimate part, manage challenges to the established rules. Such challenges may be external and/or internal to a client's most familiar and immediate systemic membership (Becvar & Becvar, 1996; Nichols & Schwartz, 1998).

Change in the rules of a client's system is known as second-order change. This level of change is distinguishable from first-order change in that the latter does not change the rules of a client system, only the behavior surrounding a particular problem (Watzlawick et al., 1974). According to Nichols and Schwartz (1998), this distinction represents a pivotal conceptual shift in counseling. In essence, linear causality prepares a trainee to conceptualize a client's problem as something that is caused by past occurrences. Subsequently, MHCs traditionally focus on treatment designed to change a particular personality characteristic (first-order change) that has been identified as the "cause" of a problem. Conversely, MFC/Ts trained in the concept of circular causality see a client's problem as something that is part of a continuing, circular feedback loop. A MFC/T trainee's attention is thereby drawn toward viewing an individual's presenting problem as part of a broader context of recurring, self-perpetuating cycles of interaction. Such cycles may be adaptive and encourage the healthy growth and development of a system and its respective members both within a system (e.g., couple) and in relationship to larger systems (e.g., family-of-origin). Or, interactive cycles may be maladaptive, producing symptoms within one (e.g., client, father, or husband) or more members of a

particular system (e.g., family). In terms of MFC/T-oriented practice, the maladaptive patterns of interaction become the focus of treatment, often centered on changing the rules (second-order change) (Becvar & Becvar, 1996; Huber & Carlson, 1994; Nichols & Schwartz, 1998; Resnikoff, 1981; Sexton, 1994; Strong & Claiborne 1982; Worden, 1994).

It is important to note that first and second-order changes are not mutually exclusive to the work and treatment focus of either MHCs or MFC/Ts. However, the respective levels of therapeutic change are traditionally associated with a particular conceptualization of causality, which is in turn traditionally promoted within a particular specialized program of training. Accordingly, linear causality is usually associated with MHC and circular causality is usually associated with MFC/T (Becvar & Becvar, 1996; Huber & Carlson, 1994; Nichols & Schwartz, 1998; Strong & Claiborne, 1982; Worden, 1994).

Content versus Process Dynamics

Just as the shift between an individual and a systemic perspective evolved from a shift in the conceptualization of causality, the alternative perspectives draw trainees to different issues occurring in the counseling/therapy process. Worden (1994) referred to this shift as content versus process and defined it as follows. Content refers to the concrete issues being presented in a counseling/therapy session. In other words, the "what" of a counseling/therapeutic discussion is often the focus of individually, linear-based conceptualization and treatment planning. Process refers to the "systemic series of interactions" (p. 7) lying beneath a counseling/therapeutic discussion. More to the point, process encourages students/trainees to focus on how a particular counseling/therapy

topic of discussion is interactionally embodied by the members of a client's system. The content-oriented trainee focuses on resolving and negotiating solutions to presenting issues. The process-oriented trainee is concerned with maladaptive patterns supporting the content issue. Respectively, the conceptualizations of MHCs and MFC/Ts have been distinguishable by a content versus process focus within a counseling/therapy session.

In summary, MHC and MFC/T are distinguishable by three closely connected concepts. MHC emphasizes an individual perspective of behavior, linear causality, and content resolution. MFC/T emphasizes a systemic perspective of behavior, circular causality, and a focus on process over content. Each point of view offers a unique means of conceptualizing client concerns and intervening in treatment, and neither paradigm diminishes the value of the other. Further, each perspective may be best thought of as a general way of understanding problems, how they occur, and how they may be resolved effectively, as opposed to a standardized theory of counseling (Worden, 1994).

Studies Related to Counselor Trainee's Conceptual Development

Case conceptualization plays a central role in the counseling/therapy process (Nathan, 1998). In working with a client, a counselor/therapist must come to understand a client's problem and make a tentative plan of action that will best address the client's needs (Strohmer & Newman, 1983). Conceptualization has received attention from all major schools of therapy as well as from the decision-making field (Waddington, 1997). The focus of this attention has been widely dispersed, including experimental studies of clinical judgment (e.g., Friedlander & Phillips, 1984; Herbert, Nelson, & Herbert, 1988; Spengler & Strohmer, 1994); professional commentary on clinical judgment (e.g., Dumont & Leconte, 1987; Rock, Bransford, Maisto, & Morey 1987); theory specific

models of conceptualization (e.g., Andersen, 1992; Barber & Crits-Christoph, 1993; Haynes & O'Brien, 1990; Persons, 1989); attempts to understand conceptualization as it is influenced by a human's (limited) information-processing capacity (e.g., Garb, 1998); explanations of how heuristics (i.e., decision-rules) influence conceptualization (e.g., Garb, 1998; Tversky & Kahneman, 1973); research on accuracy of practitioners' clinical hypotheses (e.g., Garb,1998; Schinka & Sines, 1974; Turner, 1966); attempts to understand the relationship of conceptualization to a counselor's/therapist's ability to integrate large quantities of client-related data in multidimensional ways (cognitive complexity) (e.g., Spengler & Strohmer, 1994); and the impact of client characteristics on counselor/therapist conceptualization (e.g., Garb, 1998; Stevens, 1981).

The considerable breadth of research and literature suggests that, in general, conceptualization and treatment recommendations depend on the manner in which a helping professional views the origin of a client's concerns. However, this conclusion is dependent upon a number of factors (Langer & Abelson, 1974; Plous & Zimbardo, 1986; Snyder, 1977). For example, counselor/therapist demographic variables represent one of the factors believed to impact conceptualization (Falvey, 2001; Shueman, 1997; Skovholt & Ronnestad, 1992).

The professional community's interest in conceptual development and practice has been intensified by the changing quality of health care policy (Falvey, 2001). In recent years, the managed care industry has become a powerful force in determining which mental health service providers are allowed to practice and to be reimbursed for their services. As a result, mental health providers have found it necessary to demonstrate their fitness to provide services through presentation of their academic training, level of

education, experience, and professional credentials (Falvey, 2001; Shueman, 1997). However, relevant research presents conflicting results about how counselor/therapist demographic variables impact counseling, the result of which is little professional consensus (e.g., Dawes, 1989; Garb, 1998; Gil-Adi & Newman, 1984; Skovholt & Ronnestad, 1992).

Fully investigating the complex nature of conceptualization is beyond the scope of this research. However, one aim of this study is to provide data that will contribute to the overall task. Therefore, this study focuses on the impact of some trainee demographic variables relevant to case conceptualization and treatment planning.

Conceptualization and treatment planning are widely recognized as essential competencies of counselors (Falvey, 2001; Garb, 1998; Mordock, 1994; O'Donohue, Fisher, Plaud, & Curtis, 1990). Therefore, understanding how trainee demographic variables shape these critical counselor/therapist abilities is important to multiple entities, such as the counseling profession, consumers, counselor educators, and the health care industry. The remainder of this section presents a representative sampling of what has been studied regarding counselor/therapist demographic variables.

The Influence of Demographic Variables

The majority of relevant research has investigated samples of the helping professional population outside the focus of this study. That is, trainees enrolled in academically-based counseling programs and being trained within a selected area of specialization have received little attention in regard to understanding their conceptualization and treatment planning and relationships trainee demographic variables have to these tasks (Anderson, 1992). Further, even within the existing research, the

findings are conflicting. Some research (e.g., Bishop & Richards, 1984; Falvey & Hebert, 1992; Garb, 1989; Gil-Ali & Newman, 1984; Lambert & Wertheimer, 1988) supports the notion that counselor/therapist demographics (e.g., degree, work setting, experience, professional orientation, or supervisor's/mentor's professional orientation) influence conceptualization and treatment planning. Other research (e.g., Rock et al., 1987; Spengler & Strohmer, 1994; Strohmer & Spengler, 1993; Turner & Kofoed, 1984) concludes that counselor/therapist demographic variables do not significantly influence conceptualization or treatment planning.

Brickman and associates (1982) stated that a helping professional's socialization through a particular professional affiliation is influential to treatment approach. Several studies support this contention. For example, Plous and Zimbardo (1986) investigated the conceptualization and treatment recommendations of professionals in relation to academic training (i.e., psychoanalysts, behavior therapists, and undergraduate students taking their first psychology course), level of education (i.e., no degree, masters, doctorate, or M.D.), and self-selected theoretical orientation (i.e., psychoanalytic, behavioral, or cognitive-behavioral). They suggested that diagnosis and treatment are strongly affected by a practitioner's professional orientation, and regardless of a client's presenting problems. Houts' (1984) study of doctoral-level trainees also supported the idea that a practitioner's orientation impacts conceptualization and treatment planning practices. However, when Kopta, Newman, McGovern, and Sandrock (1986) investigated the level of education, professional affiliation, and years of experience, they found that conceptualization varied significantly in accordance with the subject's professional affiliation.

Professional affiliation also appeared to stand out as a distinguishing variable in a study conducted by Simmons and Doherty (1998). In their exploratory study of how academic training influences the manner in which clinical members of AAMFT from different training backgrounds (e.g., social work, psychology, counseling, or MFT) engaged in treatment provision, 60.5% of the study's population identified their professional affiliation as marriage and family therapy. As to the impact of academic training, the study offered no relationship between training and practice. It is important to note that these findings can be generalized only to credentialed MFTs who are members of AAMFT; therefore, nothing can be gleaned about the influence of academic training in relationship to trainees' conceptualization and treatment.

Turner and Kofoed (1984) studied seventy-five mental health practitioners from social work, psychology, nursing, psychiatry, and alcohol/drug counseling. Their findings revealed that only social workers were inclined to shape their conceptualization of a client's problem in relationship to their professional affiliation. Similarly, Falvey's (1992) research on the treatment planning of experts in the fields of psychiatry, psychology, social work, psychiatric nursing, marriage and family therapy, and mental health counseling revealed no substantial differences based on professional affiliation.

Simmons' and Doherty's (1998) analysis found that a counselor's/therapist's gender and level of education (e.g., masters or doctorate obtained) had no substantial relationship to treatment planning and conceptualization. However, other studies found to the contrary regarding level of education. One example was Skovholt and Ronnestad's (1992) investigation of normative counselor/therapist development across the life span. Participants ranged from first year graduate-level trainees to practicing professionals with

more than forty years in the field. The qualitative analysis was designed to account for both personal and professional sources of influence on development. Their study illustrated that the manner in which counselors/therapists conceptualize client issues progresses from being strongly externally regulated during training to being increasingly congruent with a counselor's/therapist's personality over time. The investigators noted that the nature of graduate education demands that trainees meet the approved competency standards of the profession's gatekeepers (e.g., supervisors and professors). Competency standards come in the form of examinations, structured practica and internships, and professional socialization. "A direct result of this enormous professional pressure is the development of externally imposed rigidity in many areas of professional functioning" (p. 507), such as conceptualization. Other studies suggest that training, level of education, supervisor's/advisor's professional affiliation, and experience are integrally related to one another as it pertains to their influence on conceptualization and treatment planning.

Another study by Fong, Borders, Ethington, and Pitts (1997) illustrated the findings of Skovholt and Ronnestad (1992) empirically. Specifically, "small incremental gains in counselor cognitive functioning" (1997, p. 107) were found to occur over time during a master's-level training program. The most prominent change occurred after trainees had completed a counseling skills course. At that point, trainees' conceptualizations were focused more on a client's psychological characteristics rather than on a client's physical characteristics and interactions.

Conceptualization also has been found to be influenced by interaction with established professionals (e.g., supervisors, mentors, and advisors), peers, and personal

life experiences While the extent to which these factors impact each person is unique, interpersonal encounters with established professionals and a trainee's age at the start of graduate-level training stood out over learned theories and empirical research results as being the most important developmental factors (Skovholt & Ronnestad, 1992). However, "theory and research is often mediated through [established professionals], and in this way, both people and knowledge are of importance" (p. 509).

Newer members of the field (e.g., start of graduate education and limited experience) want "to learn from, model, please, and respect" (Skovholt & Ronnestad, 1992, p. 510) their professional elders. However, experienced professionals have moved beyond imitation and are more focused on expanding and clarifying their professional conceptualizations and approaches to treatment planning in a manner congruent with their personal sense of being. Beutler and McNabb (1981) found that the less experienced and the earlier in an education program a trainee was, the more likely he/she was influenced by the professional affiliation and preferred conceptualizations of his/her supervisor/advisor/mentor.

Regarding age at the start of graduate school, Skovholt and Ronnestad found that the older a beginning graduate student was, the more quickly the trainee progressed from a "conventional" stage of conceptualization to an "imitation of experts" stage to an "exploration" stage. However, at 10 to 30 years beyond graduate training, age did not play a significant factor in a professional's growth toward highly individualized and personally congruent conceptual ideas.

As with other demographic variables, existing research regarding a relationship between experience and the crucial clinical tasks of conceptualization and treatment

planning is inconclusive (Falvey, 2001). However, experience is not to be confused with expertise. Cummings, Slemon, and Hallberg (1993) defined expert counselors/therapists as those persons evaluated to be expert by some panel of evaluators, and experienced counselors/therapists as those with a specified number of years of counseling experience.

Dulaney and O'Connell (1963) demonstrated that experience has no relationship to how a person conceptualizes a problem. Instead, they stated that a person must have access, through learning (i.e., academic training), to a particular understanding of an issue before it can be employed. Therefore, from this point of view, experience has no direct relationship to conceptualization. However, the existing counselor development literature appears to support a relationship between experience and conceptualization (e.g., Etringer, Hillerbrand, & Claiborne 1995). Martin, Slemon, Hiebert, Hallberg, and Cummings (1989), for example, illustrated that experienced counselors/therapists were able to conceptualize information more efficiently and abstractly. Similarly, in Kivilighan and Quigley's (1991) study of the relationship between group leadership experience and conceptualization of group process, experienced (i.e., having at least one thousand hours of group therapy experience) counselors/therapists were found to have more complex views of group members, group member interactions, and ability to differentiate between group members more extensively than did novice (i.e., counseling psychology graduate students in their first group counseling course) counselors/therapists.

In general, the research suggests more frequently that experience is essential to the development of effective conceptualization and problem solving abilities (Martin et al., 1989). Presumably, conceptualization and treatment planning involve complex interactions between acquired knowledge, repeated experience, and cognitive processes

that promote the connection between knowledge acquired and a counseling/therapy situation (Gick, 1986).

It is important to note that research on the influence of family therapy training has been conducted primarily in postgraduate degree programs rather than academically based programs (Anderson, 1992). For example, Tucker and Pinsof (1984) examined trainees' conceptualization changes after completion of the first year of a two-year, postgraduate, MFT program. They found significant movement toward a family systems conceptualization of clinical problems on one of three scales used. Their findings also revealed that academic training, level of education, and experience prior to training did not result in differences in the trainees' grasp of clinical problems. Perlesz, Stolk, and Firestone (1990) found improvement in trainees' (MFC/T-oriented) conceptualizations of client problems at the completion of a two-year, postgraduate MFT training program. Unfortunately, no studies were found that evaluated the conceptualization and treatment planning qualities of MFC/Ts trained within an academically based program.

The available research base directed toward clarification of the influence of counselor/therapist demographics on conceptualization and treatment planning is limited in its direct application to students/trainees. Nonetheless, the literature does suggest that demographics such as educational training level, experience, professional affiliation of both the student/trainee and the supervisor/mentor, and age are important variables to consider in relation to the focus of this study.

Challenges that Relate to Conceptualization of MHCs and MFC/Ts

Trainees entering a counseling program typically have been exposed to numerous theories that include focus on the experience of the individual. Further, the common

language used to identify a person's problem (i.e., the DSM-IV-R) is based on the medical model, which necessitates that a trainee conceptualizes a client's concerns from an individual orientation (Huber & Carlson, 1994; Worden, 1994). Consideration of individual dynamics also is reinforced by rich resources of individual personality theories (e.g., Freudian psychodynamic theory), current psychiatric diagnostic system of disorders (e.g., Diagnostic and Statistical Manual IV-R), developmental psychology studies focused on an individual's development across the lifespan, and each person's particular experience of the world (Worden, 1994). The value of the latter is particularly apparent in that a person always has his/her particular viewing lens of the world in operation.

Avis and Sprenkle (1990) evaluated fifteen empirical studies focused on training in MFC/T. Of the fifteen studies, nine were concerned with training methods and formats and six addressed the development of instrumentation. Training, in these studies, ranged in duration (e.g., intensive, year long training to brief or three-day workshops), population (e.g., students in medical school, MSWs, counseling graduate students, practicing MFC/Ts, and graduate-level students in MFC/T), and participants' experience level (e.g., students to licensed practitioners). Specific to this investigation, Avis and Sprenkle (1990) concluded that empirical research in MFC/T is limited, many studies lack replication, and evidence exists that training can improve a trainee's ability to systemically conceptualize the causal components of clients' presenting problems. However, of the fifteen studies reviewed, most did not control for important trainee variables such as gender, experience level, and professional orientation of a primary supervisor/advisor.

As a general rule, education in the field of psychology/counseling introduces trainees to the many individual personality theories significant to the development of MHC and MFC/T. With such powerful supporting resources, Huber and Carlson (1994) noted that shifting from an individual (e.g., MHC) to a systems (e.g., MFC/T) perspective can be a difficult task. In essence, systemic thinking is not the psychosocial norm of modern western culture (Sexton, 1994). As a result, systemically oriented trainees may face additional practice, legal, and ethical considerations in implementing their views. For example, a systemically oriented trainee must be able to understand and communicate a client's individually oriented experiences in a manner that validates the client's view yet allows the trainee to maintain a broader interactional perspective (Sexton, 1994; Sluzki, 1978). The purpose here is not to debate the merits of either approach or determine the treatment of choice. Rather, the point is that a trainee's level of education, professional orientation, experience, and/or the professional orientation of his/her supervisor/advisor may indeed impact his/her conceptual tendencies.

Support for Methodology and Instrumentation

This section is focused on the method by which conceptualization and treatment planning characteristics will be determined. Attention is given first to theory and then to appropriate methodology.

Schema Theory

Schema theory is rooted in constructivist metatheory and emerged from contemporary cognitive psychology. Constructivist theory holds that human perception results from a person's mediation and transformation of external experiences through internally constructed cognitive structures or schemata (Pace, 1988). Many influential

theorists have proposed types of constructivist theory for inquiry into human problems, change, and processes of counseling (e.g., Bartlett, 1932; Beck, 1976; Frank, 1973; Kelly, 1955; Piaget, 1977).

There exists within constructivist metatheory three basic schools of thought: the traditional, social constructivism, and integrated constructivist views. These perspectives differ by the roles given to nature, cognitive factors, and social factors as explanations of knowledge development. The integrated constructivist approach to understanding conceptual development is of primary interest here. It encompasses social and cognitive factors as well as nature (Chinn, 1998). Chinn argued that integrated constructivism is frequently the approach of choice for addressing questions about conceptual development adequately. As with other theoretical approaches, integrated constructivism encompasses different schools of thought. One particular application of integrated constructivism is schema theory (Chinn, 1998; Pace, 1988; Popper & Eccles, 1977).

Schema theory allows taking into account variables and characteristics within the complex nature of conceptual development. Additionally, because nature and society play a strong role in determining cognitive structures and applications thereof, questions can be posed that are not addressable within other theories (Chinn, 1998). For example, how does a trainee's identification with a particular professional organization relate to conceptualization of client concerns and treatment planning? Or, what influence does culture have on a trainee's conceptualizations? Thus, Chinn (1998) and Pace (1988) present a compelling argument for the use of schema theory in the study of conceptual development related to counseling processes.

Schema theory holds that individuals develop knowledge configurations through interaction with their surroundings and conceptual antecedents. Such knowledge configurations are generally known as schemata. Schemata are defined as "unconscious mental structures and processes that underlie the molar aspects of human knowledge and skill" (Brewer & Nakamura, 1984, p. 140), "the medium by which the past affects the future" (Neisser, 1976, p. 22), and as the mechanism by which effective thinking and action are possible because schemata allow a person to select, limit, and organize information in a meaningful manner (Mandler, 1984). According to Taylor and Crocker (1981), schemata are domain specific cognitive structures consisting of hypotheses about incoming information. These hypotheses mediate the plan for gathering, interpreting, and utilizing information. Further, schemata, by attending to how the complex integration of social and natural factors influences cognition, also can account for distortions in information processing.

In part, knowledge is embedded in and gained from social interaction. Meaning thus is "socially negotiated" and has value within the context of the community in which a person exists (Chinn, 1998; Thagard, 1994). The process of learning MHC and MFT/C concepts thus involves social interaction (e.g., structured learning activities or supervision). Similarly, a trainee's individual and cultural characteristic interact with the process of training in MHC and MFT/C to shape conceptual development (Mandler, 1984).

Nature also plays a key role in understanding the influence of MFT/C and MHC training on conceptualization and treatment planning. Chinn (1998) found that, in most cases, conceptualization is limited to the explanation that best fits the data for the

situation. Therefore, conceptualization is strongly shaped by the elements of the natural environment.

In sum, social factors and nature are integrally connected to understanding cognition/conceptual development and how people approach problems (Chinn, 1998). The development and application of alternative explanations/concepts is bounded by an individual's depth and breadth of knowledge, data from the physical world (nature), and social factors (e.g., situational or personal relational experience). According to Pace (1988), the constructivist schema theory perspective is relevant and applicable to the characteristically complex nature of conceptual development and treatment planning. A major strength of this perspective is a framework that accounts for differences in information processing based on events that are inconsistent with a trainee's conceptual schema and/or current level of training, and/or are emotionally charged or highly ambiguous.

Assessment Instrumentation

Several factors guide data collection methodology, including the nature of the information sought and the research questions. Also to be considered are the geographical location of participants, extent of researcher-participant interaction, monetary resources, and time (Alreck & Settle, 1995). Given that this study does not attempt "to *do anything* to [trainees], apart from asking them to provide information in response" (Jaeger, 1997, p.53) to particular case vignettes, survey research is an appropriate methodology.

Internet and web-based survey research

Traditional survey research is beset with methodological problems. For example, a traditional pen-and-paper, mailed survey may prove to be cost and time prohibitive.

Also, surveys personally administered by a researcher may increase a subject's potential to please the researcher, thereby yielding only socially desirable responses. Self-administered, pen-and-paper surveys also have relatively low response rates and relatively high item completion errors (Issac & Michael, 1995; Kiesler & Sproull, 1986). Technological advances have created new means to conduct survey research (Pealer, 1999); the Internet is such a technology.

Between the end of 2000 and June 2001, 8.4 million new Internet users went online. Currently, over 65 million U.S. households actively use the Internet and WWW (Thorsberg, 2002). The Pew Internet and American Life Project reports that Internet use for many residents of the U.S. is now "indispensable" (Well, 2002). Further, institutions of higher learning now commonly require students to have access to the Internet to complete their degree programs successfully (e.g., University of Florida Admissions, 2002; University of Nevada, Las Vegas, 2002).

These resources allow researchers to address some of the problems inherent in traditional survey research. For example, Parker (1992) found a 68% response rate with an electronic mail (i.e., via e-mail) survey versus a 38% return rate for a traditional, mailed, pen-and-paper, self-administered format. Web-based surveys also are less expensive or time consuming to design and distribute (Gaddis, 1998). Participants also may be more likely to respond to Web-based surveys outside the socially desirable response realm due to the anonymity of the medium (Houston & Fiore, 1998). Web-based surveys also have been found to have fewer item completion errors (Kiesler & Sproull, 1986). Finally, participants reported finding web-based surveys more interesting

and to have a sense of scientific value, privacy, and legitimacy (Tourangeau & Smith, 1996).

Web-based surveys present still other advantages, including being able to respond in an "intuitive, non-labor intensive manner" (Pitkow & Recker, 1995, p.809). Ease of survey completion, along with interest, in turn has been found to be influential to response rate (Pealer, 1999). Within Web-based surveys, participants' responses can be recorded automatically, thereby eliminating transcription errors (1995). Furthermore, participants reasonably can be ensured that their responses will be kept confidential and/or anonymous due to encryption techniques (Kurland, 1996). Pealer's study (1999) stands as a good example that Web-based survey research is a viable method for collecting data from a university population.

Although Web-based surveys have distinct advantages, they also have limitations. Some are the same as for traditional surveys and others are unique to the medium. For example, both methods suffer from a not easily resolved problem of incomplete survey submissions (Schmidt, 1997). Also, incentives may influence response rates. Denton, Tsai, and Chevrette (1988) recommended use of tangible incentives (e.g., online coupons or request for results of study) for participants to receive upon completion of the survey. Computer hardware, survey software, and Internet access factors present researchers and participants with substantial costs. Fortunately, these costs may be avoided when researchers and participants are affiliated with an institution which has unlimited access to the Internet (Gaddis, 1998; Schmidt, 1997).

The use of Web-based surveys for data collection is frequently used for marketing and business purposes. However, academic researchers have learned quickly and applied

the technology to their research. Indeed, as of mid-2002, the American Psychological Society was conducting well over 100 Internet and/or Web-based studies, ranging from causal reasoning surveys to those concerned with organizational decision making (Krantz, 2002). In 2001, Chi Sigma Iota, an international honor society of counseling academicians and practitioners, devoted a series of articles in their newsletter to the use of computer technology in counselor education. In it, Leech and Greene (2001) wrote that use of computer technology and the Internet in counselor education is not a question of "if, but how" (p.8). The technology thus has been recognized as an important medium for education, conducting meaningful research (Bell & Kahn, 1996; Birnbaum, 2000), and providing access to a growing and widespread population of research participants (Houston & Fiore, 1998).

Use of case vignettes

When faced with the task of assessing trainee conceptualization and treatment planning characteristics, numerous techniques have been developed. For example, a trainee's conceptualization and treatment planning has been evaluated through the use of "real" client counseling/therapy video and audiotapes, live supervision of "real" client counseling/therapy sessions, paper-and-pencil examinations, role-playing clinical situations, and student/trainee personal journaling. Each of these methods has its strengths and limitations. However, use of case vignettes seems to be the most advantageous (McLeod, 1992). Therefore, this study employs case vignettes.

Case vignettes/simulations of clinical practice situations have many potential applications (Berven, 1985; Falvey & Hebert, 1992). For example, in the field of medicine, vignettes referred to as *patient management problems* have long been used as a

general clinical problem-solving assessment tool. A medical student is given a brief written or audiovisual description of a patient's relevant history and presenting problem. Students then select from a list of potential interventions (e.g., medication or hospitalization). Intervention selection continues until no further action is deemed necessary. From this information, medical students' conceptualization and treatment abilities are evaluated (Berven, 1985). In 1961, the National Board of Medical Examiners began using this method in its examinations. Smith (1983) reported that at least eight medical specialties utilize the vignette technique in their certification examinations. Computerized formats also have been used in medical education and certification processes (e.g., Friedman, Korst, Schultz, Beatty, & Entine, 1978; Schumacher, Burg, & Taylor, 1975; Taylor, Grace, Taylor, Fincham, & Skakun, 1976).

The use of clinical vignettes/simulations also can be found in the fields of psychology and business. For example, Berven and Scofield (1980) employed simulations, in computerized form, to assess the clinical problem-solving abilities of graduate students in rehabilitation counseling. Smith (1983) also described the potential credentialing applications of this methodology for the practice of psychology. Pegorsch (1998) noted that business employers have used case simulations successfully to select personnel, finding the method to have strong validity and to be a reasonable predictor of a potential employee's job performance.

In recent years, the counseling field has embraced this methodology. For example, Berven and Scofield (1980) demonstrated that this method is useful to study decision-making styles as related to the clinical judgments of rehabilitation and mental health counselors. Case vignettes also have been used effectively to study a trainee's ability to

cope with ambiguity and develop a clear rationale for professional and ethical decisions (Frame, Flanagan, Frederick, Gold, & Harris, 1997). The American Mental Health Counselors Association (AMHCA) investigated the psychometric properties of case simulations and found that clinical treatment planning simulations were highly reliable and demonstrated adequate content, discriminant, and predictive validity (Falvey & Hebert, 1992).

Clinical vignettes also have been found to be effective in terms of cost, time and ease of administration (Peabody, Luck, Glassman, Dresselhaus, & Lee, 2000). Van Zuuren, de Groot, Mulder, and Muris (1995) suggested the advantage that persons being assessed have roughly the same situation in mind when responding to a given scenario. Furthermore, investigators are able to control effectively for case mix (Peabody et al., 2000).

Case vignettes also have been shown to be sensitive to change in knowledge and skills (e.g., Sriram et al., 1990), and to differentiate a participant's grasp of concepts and information (e.g., Carroll, 1993), and are correlated positively to clinical skills (e.g., Mortowildo, Dunnette, & Carter, 1990; Sriram et al., 1990). Skaner, Bring, Ullman, and Strender (2000) concluded use of vignettes is acceptable for making group comparisons, a finding previously illustrated by Sandvik (1996). And, finally, Peabody and associates (2000) concluded that clinical simulations provide a valuable way of assessing the quality of care among different providers in different systems of care and with different populations.

Summary

In Lindvall's (1959) article concerning the purpose of the review of related research, he contended that the researcher should be concerned primarily with relating his/her investigation to the findings of others, so that when combined, they help to complete an integrated pattern of research results. In this review of related research, an attempt has been made to select those studies most directly related to this investigation and to create a framework of thought that produces an important problem and documents its significance.

CHAPTER 3
METHODOLOGY

The solution of a problem requires a plan of action by which to study as efficiently as possible the problem and to arrive at valid conclusions with respect to it. The soundness of this design, and its workability when put into operation, are important to the success of the study. This chapter deals with the planning and execution of the design for this study. Included are descriptions of the population, sample, methodological procedures, research variables, data analyses, and methodological limitations.

General Design

This study employed an internet-based, survey research to examine how trainees currently enrolled in master's and doctoral-level CACREP-approved MHC or MFC/T preparation programs select different conceptualizations of clients' concerns. Surveys (e.g., pen-and-paper, computer-based, and interviews) are used extensively in educational research to collect information that is not readily and/or directly observable (Gall, Borg, & Gall, 1996). Surveys also are used to examine a respondent's status with respect to a particular variable of interest (e.g., conceptualization), but not to determine how subjects respond to a particular action taken by the researcher (Jaeger, 1997). Surveys thus allow researchers to investigate a wide range of educational problems (Gall et al., 1996).

Gall, Borg, and Gall (1996) wrote that surveys intended to measure skills such as conceptualization generally must be constructed using a scale that allows for indication of the extent of agreement with a particular item. These types of survey assessments must

use a relatively large number of items, "at least 10" (p.297), to obtain a reliable assessment of what is being measured. This study presented respondents with three case vignettes and six responses for each vignette. Respondents were asked to select how likely they were to conceptualize or plan treatment according to each response following a particular vignette. A ten-point response scale ranging from "extremely unlikely" to "extremely likely" that represents how a respondent might conceptualize and/or plan treatment according to a given response was included. A total of 18 responses for each participant were to be obtained.

The survey was distributed via the Internet. This distribution method was selected because of the advantages the Internet provides with regard to considerations of cost, administration, and geographical location of the population (Albert, Cluxton, & Miller, 1997; Pitkow & Recker, 1995). Participants were reasonably ensured that their responses were kept confidential and/or anonymous due to encryption techniques (Kurland, 1996).

Prior to formal distribution of a survey, it was tested to eliminate weaknesses and address issues of validity (Albert et al., 1997; Gall et al., 1996). A panel of experts reviewed and evaluated the survey instrument. This process allowed the survey to be adjusted to establish an evidentiary basis for content relevance and representativeness, technical quality, and construct validity (Albert et al., 1997; Messick, 1980).

Population

The respondents for this study had completed an undergraduate degree program and were currently enrolled in college or university-based, graduate-level preparation program to become a counselor/therapist. This study was confined to programs accredited by CACREP in the areas of MHC, MFC/T, and Counselor Education and Supervision.

Programs fitting eligibility criteria were housed in more than one administrative unit (e.g., department, division, or college) of universities or colleges. Thus, administrative units were used to determine the population (Hollis, 1997). Administrative units housing eligible programs were identified through ACA's *Directory of Accredited Programs 2002* (available on-line) and institutions listed in *Counselor Preparation 1996-1998: Programs, Faculty, Trends, Ninth Edition* (Hollis, 1997). As of May 2002, 73 universities/colleges housed 84 administrative units that offered 96 programs appropriate to this study. At the master's-level, CACREP reported 27 MHC-accredited programs and 26 MHC/T-accredited programs nationally. At the doctoral level, 43 CACREP-accredited programs were identified.

Based on responses supplied for Hollis' (1997) review of counselor preparation and the 2002-03 online version of the *Occupational Outlook Handbook* (OOH), several factors can be noted about this population. At the master's-level of education and training in MHC and MFC/T, trainees' undergraduate G.P.A.s ranged from 2.5 to 3.5. Their eligibility for enrollment in master's-level MHC and MFC/T programs commonly required meeting a cutoff score on the GRE and/or MAT, submitting letters of reference, providing evidence of work experience, and participating in a personal interview. An average of fifty trainees were enrolled per program/per year. Some programs had as few as four students and others had as many as 200. Master's-level MHC and MFC/T programs graduated approximately equal amounts of trainees annually, with a 3:1 ratio of female to male graduates (1997). Master of Arts (M.A) and Master of Science (M.S.) are the two major degrees granted to trainees completing these programs. The next highest degree frequency in MHC and MFC/T was an Education Specialist (Ed.S).

At the doctoral level of training, trainees are typically granted admission upon completion of a master's degree in a compatible program as well as meeting admission requirements similar to those applied at the master's level. The range of students per doctoral program was 2 to 90 in 1996. On average, programs graduate nine doctoral-level trainees per year. Female doctoral-level graduates outnumbered males by a ratio of 2:1. The Ph.D. and the Ed.D. were the degrees commonly granted upon completion of a doctoral-level program (Hollis, 1997).

A precise trainee enrollment count was unknown. However, estimations were obtained by extrapolation of data from several resources (e.g., Hollis, 1997; OOH, 2002). Where information was available, the basis for extrapolating enrollment data was formed from administrative units identified as providing CACREP-approved programs terminating in a M.A., M.S., Ed.S., Ph.D., and/or Ed.D. degree. As of 1998, an estimate of more than 3200 trainees were enrolled in one of the CACREP-approved programs of interest. It may be noted that Hollis's finding that enrollment appears to be on an upward trend is consistent with the job market overview provided by the OOH (2002).

Counselors/therapists were estimated to hold 465,000 jobs in 2000. Of these, 67,000 specifically were mental health counselors and 21,000 were marriage and family counselors/therapists. Settings in which masters and doctoral-level graduates were employed were varied and included work in private and public healthcare organizations, health maintenance organizations, and educational institutions. The *Occupational Outlook Handbook 2002-2003* estimated that employment for counselors/therapists was expected to grow faster than the average for all other occupations through 2010.

Additionally, with many counselors reaching retirement age, many new job opportunities were predicted to become available (2002).

Sample

It usually is not practical to study an entire population of interest (Sarvela & McDermott, 1993). Therefore, sampling allows researchers to examine a portion of a population and "to make valid generalizations after careful measurement of the variables of interest in a relatively small segment of the population" (p.221). Soliciting newsgroups or listservs related to a research topic has proven an effective method by which to recruit subjects on the Internet (Birnbaum, 1999, 2000; Mehta & Sivadas, 1995). Several listservs were identified as being related to or developed for this study's eligible population. *Counsgrads* was a listserv developed specifically to help graduate students across the country communicate with one another (listserver@lists.acs.ohio-state.edu) and had approximately 800 members. The American Mental Health Counselors Association hosts a national graduate student listserv (join-students@lyris.amhca.org). The listserv *Diversegrad-L* provided a medium by which students, counselors, educators, among others may communicate about issues of diversity in the counseling profession (Diversegrad-L@listserv.american.edu). ACA hosted a listserv designed to enhance global communication among counselors (ACA-INT-SUBSCRIBE-REQUEST@home.ease.lsoft.com). Another counseling listserv that reported members, including graduate students, from every state in the U.S. and several countries was the *International Counselor Network* (listserv@utkvm1.utk.edu). *GROUPSTUFF*, at majordomo@indiana.edu, targeted students and professionals interested in group counseling. Relevant information about this study also was distributed on a listserv

specifically for Counselor Educators (*CESNET-L* at majordomo@www2.colstate.edu), a listserv for the discussion of counseling theory, research, and practice with couples and families from a family systems perspective (IAMFCNET-L@baylor.edu, and a listserv for mental health students and professionals (*PsychNews: Mental health newsletter* at listserv@vm1.nodak.edu).

Eligible trainees were contacted via e-mail (Appendix A) regarding the purpose and method of this investigation. They were asked to click on the direct link provided and to complete the survey before Friday, October 04, 2002. They also were asked to distribute this information to other trainees in their department.

Program chairpersons also were to be contacted via email regarding the purpose and method of this investigation and asked to distribute relevant investigation information to faculty, and/or students/trainees in their respective departments. However, the University of Florida Institutional Review Board was concerned about the recruitment method, stating "students may feel pressured to participate." As a result, the original study plan was revised to address these concerns. Appendix L details this process.

The sample sought for this study was approximately 200 trainees currently enrolled in masters-level MHC, masters-level MFC/T, or doctoral-level Counselor Education programs. Demographic information was collected to allow complete description of the resultant sample. To obtain an adequate sample, the survey deadline was extended to Sunday, October 27, 2002.

Methodological Procedures

Following are descriptions of the major elements of procedures and resources actually used in this study.

Instrumentation

A four-task process for participants to complete was developed. Three tasks (i.e., obtaining informed consent and demographic information and responses to case vignette options) were essential to the collection of complete data. The fourth task (i.e., request for results) was optional.

Three case vignettes/simulations of situations that trainees were likely to encounter in professional practice and six selected conceptual responses for each of the three vignettes respectively were developed. The vignettes were selected to be standard stimuli to assess clinical judgment in case conceptualization and treatment planning (Falvey, 2001). Acknowledged experts in the field of counseling/therapy originally developed the three vignettes selected for this study. Permission to reprint each vignette was requested and granted by the respective publishers (Appendix F). Vignette one is from the *DSM-IV-TR Case Book* by Spitzer, Gibbon, Skodol, Williams, and First (2002). Vignette two is from *Family Therapy Basics* by Worden (1994). Vignette three is from *DSM-IV Made Easy: The Clinician's Guide To Diagnosis* by Morrison (1995).

The purpose of the instrument was to examine the likelihood with which trainees would select different conceptualizations of clients' concerns. There were six conceptualization responses for each vignette. Each response was intended to reflect a different conceptual dimension: individual dynamics, systemic dynamics, linear causality, circular causality, content focus, or process focus.

In order to establish that data generated from this instrument would provide reasonable answers to the research questions posed and would fit existing theory and research, the instrument was reviewed and evaluated to validate response choice type

prior to conducting the study (Bordens & Abbott, 1991). A panel of reviewers was assembled on the basis of standards commonly used to qualify experts in the field of counseling (Falvey, 1992; Hogan, 1979). Panelists were qualified to participate in the construct validation process if they met three of the following five criteria: (a) membership in a major professional organization (i.e., ACA, AAMFT, or APA) of his/her discipline, (b) possession of highest degree awarded by his/her profession, (c) hold an active license (i.e., LMFT, LMHC, CPC, and LPC) to practice counseling/therapy and/or National Board Counselor Certification (NBCC) (e.g., NCC), (d) at least five years of experience in research, practice, and/or educational settings, and/or (e) published in referred journals and/or presented at regional and/or national level professional meetings within the last five years. Verification of a panelist's eligibility was established through review of individual vitae and/or a potential panelist's completion of a brief data form.

Chapters 1 and 2 of this study presented a foundation for several of the generally accepted practices for establishing construct validity (Sax, 1990), including demonstrating that conceptualization and treatment planning have important educational, psychological, or practice implications, and illustrating that varying manners of conceptualization can be distinguished. The remainder of this section describes how construct validity was further established.

Qualified panelists who agreed to participate in this process were given a brief description of the purpose of the study, a list of seven possible response types, and a definition of each (Appendix I). They also were provided with the three case simulations and eighteen response choices (Appendix J). They were asked to select which of the

seven response choices/conceptual dimensions best described each clinical vignette response. Panelists made their selections by putting a check mark next to their selected response type. The seven response types included the six types (e.g., individual dynamics, systemic dynamics, linear causality, circular causality, content focus, and process focus) used in this study and one response type (e.g., equilibrium focus) not used in this study. Construct validity was determined to have been satisfied when the panel of experts reached at least an 80% agreement for each of the eighteen responses. Until this rate of agreement was obtained, the responses were rewritten and redistributed for evaluation. Appendix K presents this process in greater detail.

Based on the expert panel selection criteria, the panel (across all rounds) represented three nationally recognized health professions, a variety of counseling specializations (e.g., MFC/T, MHC, substance abuse, gerontology, and career), and five states. The panel was 40% male and 60% female, which is reflective of Hollis' (1997) reported gender composition of MHC and MFC/T graduates. All panelists were credentialed professionals, with 40% holding more than one license in MHC, MFC, LPC, CPC, or psychology. The NBCC had certified 80% of the panel. Panelists' work settings and years of experience reflected between five and twenty-five years as a practitioner, educator, researcher, or some combination thereof. Sixty percent of the panel had completed the highest degree offered in his/her profession and the remaining panelists had been awarded a minimum of an Ed.S. and/or were near completion of his/her terminal degree (e.g., Ph.D. or Ed.D.).

Human Subjects

Prior to initiation of this study, an application was submitted to the University of Florida Institutional Review Board (UFIRB). The duty of UFIRB is to ensure that the rights, dignity, and welfare of human participants are protected and that participation is voluntary, privacy protected, and safety assured (University of Florida, 2002a). This study, project #2002-624, was approved for August 2002 to August 2003 (Appendix L).

Data Collection

Subsequent to addressing issues central to construct validation, trainees were contacted regarding the investigation. Relevant information was distributed on listservs directly related to or designed for this study's population. These initial contacts were made on Monday, September 23, 2002. Trainees who were members of these listservs were informed of the purpose and survey methodology. They also were asked to click on the direct link provided and to complete the survey before Friday, October 04, 2002. They also were asked to distribute this information to other trainees in their department.

Having accessed the survey via direct link, participants were informed of the purpose, methodology, risks of participation, and persons to whom they could direct questions. They were then asked to select electronically the "go to survey" link, which indicated that the trainee had read and understood the procedure described and agreed to participate voluntarily (Appendix B).

Trainees responded to a demographic questionnaire, eighteen conceptual responses based on three different case simulations/vignettes, and the opportunity to request results of the survey. For ease of use, participants selected their responses via point-and-click of the computer mouse. Demographic information (Appendix C) was

collected to ensure that participants fit the eligibility criteria. Participants were instructed to click the "go to vignettes" button. Participants will be reminded to click the button only once, thereby reducing duplication error. This reminder was carefully highlighted throughout the process.

Having clicked "go to vignettes," the vignettes and corresponding response options appeared on a participant's computer monitor (Appendix D). Following each simulation, six possible responses were provided. They were asked to select the likelihood with which each might conceptualize and/or plan therapeutic intervention in the manner described in the respective responses.

Each response had a scale of extremely unlikely to extremely likely (weighted 1 to 10). Upon completion, participants were instructed to (electronically) "submit now" their responses. At this point, participants were immediately directed to a "request for results" page (Appendix E). There, appreciation for their participation was conveyed and they had the opportunity to request the results of this study. The "request for results" information was not related in any manner to the person's responses.

Approximately one week after the initial request for participants was posted to appropriate listservs, a follow up e-mail was posted (Appendix G). On or about one day after the date requested for participants to have completed the survey, a computation of the initial response rate was calculated. The researcher extended the deadline for survey completion and another follow up e-mail (Appendix H) was sent to appropriate listservs.

This process of data collection was possible through the use of the computer software specifically designed to allow researchers to design or modify a survey/questionnaire in a word processing interface. The software converted the

survey/questionnaire into a publishable format for the Web, collected and stored survey responses, and calculated summary statistics and frequencies. Data also were exported in an ASCII format to be used by the Statistical Analysis System (SAS) (Truppin, Benson, Nelson, Washburn, & Henning, 1997).

Research Variables

This study had eight independent variables, including the trainee's:

1. Gender (e.g., male or female)
2. Age category in years (i.e., 20-29, 30-39, 40-49, and 50+)
3. Current Program enrollment (i.e., MHC-masters, MFC/T-masters, CES-doctorate with emphasis in MHC, or CES-doctorate with emphasis in MFC/T)
4. Program's Accreditation (i.e., CACREP, COAMFTE, and/or APA)
5. Level of Experience (i.e., Practicum 1 = up to 150 contact hours/40 hours face-to-face, Practicum 2 = 150-400 contact hours/40-60 hours face-to-face, Internship in Counseling & Development = 400-1000 contact hours/100-350 hours face-to-face, Completed ALL M.A./Ed.S. level clinical experiences, Internship in Counseling & Development = advanced clinical experience at doctoral-level, Internship in Counselor Education = Doctoral level, Completed ALL masters and doctoral-level internships
6. Primary Type of Practicum/Internship Experience (i.e., MHC or MFC/T setting)
7. Professional Affiliation, if any (i.e., AMHCA, IAMFC, ACES or none)
8. Primary Professional Affiliation of Supervisor/Educator (i.e., AMHCA, IAMFC, ACES with a specialization in MHC, ACES with a specialization in MFC/T, or none).

The dependent variables were the trainees' indications (i.e., ratings) of likelihood of conceptualizing each of the three vignettes in accordance with the each of the six response possibilities.

Data Analyses

The response rating means, standard deviations, and frequency distributions were computed for the total sample and by program type. Next, correlations were computed between each of the18 ratings and age. *t-tests* for independent means were calculated to determine if there were differences in the ratings based on gender. Factorial analyses of variance were computed to determine if there were significant differences among the means based on various factors. For example, a 4 x 4 (age category x academic major) factorial ANOVA, a 2 x 4 (gender x academic major) factorial ANOVA, and an 8 x 2 (experience level x type of experience) factorial analysis were calculated.

Methodological Limitations

The following limitations are applicable to the conduct of this study:

1. Not all trainees eligible to participate were notified of the opportunity to participate. Notification was dependent upon membership on one of the identified listservs and/or the transfer of relevant information from listserv subscribers. E-mail messages may have been purged after a certain period of time, may have been forgotten if not completed immediately, or misplaced (Goree & Marsalek, 1995; Kittleson, 1997). However, requests for participants in this study were designed in accordance with Kittleson's (1997) study that determined that 1, 2, or 4 reminder messages was the optimal number to receive the highest response rate among professionals in the field of Health Education. Good (1997) concluded that response rate was influenced most by use of follow-up messages.

2. Some participants may not have had access to a computer and the Internet, be computer illiterate, or be unable to comply with instructions for the study (Goree & Marsalek, 1995; Kittleson, 1997). However, while this limitation was inherent in computer, internet-based research, institutions of higher learning commonly required students to be computer literate and to have access to the Internet. Furthermore, survey participants can "complete forms that are visually and functionally identical to conventional questionnaires" (Houston & Fiore, 1998, p. 17). Consequently, this limitation was not likely to be of significance among the respondents for this study.

3. Variations in the participants' computer hardware and operating systems software may have affected the trainees' participation in the study. However, new

developments in computer software programs make this concern of unlikely significance to this study.

4. Internet-based surveys may suffer from multiple submissions and/or incomplete surveys (Schmidt, 1997). However, the problem of multiple submissions was resolved by using a well-written common gateway program. It also was helpful to post a reminder to only click once to responses. Many computer users have been conditioned to double click in programs, but the Web's hypertext does not require double clicking. Consequently, the use of these methods made this concern of less significance. Unfortunately, incomplete form submission, like that for pen-and-paper surveys, was not easily resolved. Programs could have been written to return participants to the survey when not completed; however, this raised ethical considerations given that participation was voluntary and could terminated at any time.

5. Validity of research using case vignettes is contingent upon the extent to which respondents can envision themselves in the situations portrayed. Vignettes were selected on the basis that each provided standard stimuli for assessing clinical judgment in case conceptualization, treatment planning, and diagnostic tasks (Falvey, 2001). The three vignettes selected for this study were originally developed by acknowledged experts in the field of counseling/therapy are readily available in published counselor education resources, are likely to be situations discussed in learning environments, and/or situations participants have already encountered. Therefore, this limitation was not likely to be significant among the respondents.

6. Trainees had different levels of identification with the 18 response choices presented in this study. In fact, participants may have preferred a response not illustrated in any of the given response choices. However, like the previous limitation, response choices were carefully developed and evaluated for the purposes of this study. Therefore, again, this limitation was unlikely to be of significance to the study's findings.

Summary

The methods and materials used to conduct this study were presented in this chapter and included descriptions of the population, sample, research design, data collection, research variables, data analysis, and methodological limitations.

CHAPTER 4
RESULTS

Presented in this chapter are the results of an internet-based survey study to examine how trainees currently enrolled in master's-level and doctoral-level CACREP-accredited MHC or MFC/T preparation programs select different conceptualizations of clients' concerns. The data were analyzed and are presented as follows: demographics of participants by total sample and by current program enrollment, and response rating means and standard deviations provided by program type. Also, an 18 x 18 intercorrelation matrix is presented to examine relationships among responses of participants in like preparation programs. Finally, hypotheses for each of three vignettes and the six response types are analyzed. *Post hoc* analyses for significant differences among participant subgroup responses are reported where appropriate.

Participant Demographics

Two hundred and four trainees in the program areas of MHC, MFC/T, or Counselor Education and Supervision with an emphasis in MHC or MFC/T participated. The sample included 157 females (76.96%) and 47 males (23.04%). Seventy-seven (37.75%) of the participants were between the ages of 20 and 29, 54 (26.47%) were between ages 30 and 39, 48 (23.53%) were between ages 40 and 49, and 25 (12.25%) were 50 years of age or older. Of these participants, 169 (83.25%) were currently enrolled in a CACREP-accredited program, 18 (8.87%) in CACREP and APA-accredited programs, 14 (7.00%) in CACREP and COAMFTE-accredited programs, and one (.49%)

was reported to be currently enrolled in either a program with COAMFTE accreditation only or APA accreditation only. The latter respondents' data were not included in response rating analyses by program accreditation type because one person does not constitute a sufficient basis for evaluation by that type.

At the time of this study, 109 (53.70%) participants indicated not having a preferred professional affiliation, 40 (19.70%) preferred an ACES association, 31 (15.27%) indicated a preference for AMHCA, 23 (11.33%) selected IAMFC as their preferred professional affiliation, and one participant did not respond to this question. Participants indicated the following distribution as the primary professional organizational affiliation of the person (e.g., supervisor, instructor, or advisor) considered most influential to their education and training: 24 (11.82%) had a primary ACES affiliation and specialized in MFC/T, 49 (24.14%) primarily affiliated with ACES and specialized in MHC, 37 (18.23%) had an AMHCA primary affiliation, 17 (8.37%) had an IAMFC primary affiliation, and 76 (37.44%) were reported as not having a primary professional affiliation.

Among the 204 respondents, 159 (77.94%) had clinical experience primarily in a MHC setting and 45 (22.06%) had experienced their clinical work primarily in a MFC/T setting. The number of participants having no supervised clinical experience was 53 (26.50%). Twenty-one (10.50%) had completed or were currently enrolled in their first Practicum, 17 (8.5%) were at the Practicum 2 level, 32 (16.00%) were at the Internship, 60 (30.00%) had completed all M.A./Ed.S. level clinical experiences, and 2 (1.00%) were at the post master's-level of clinical experience. At the doctoral-level of clinical experience, 12 (6.00%) indicated having completed all masters and doctoral-level clinical

experiences and three (1.50%) reported being at the internship level. Program enrollments were represented by 19 (9.31%) in CES with an emphasis in MFC/T, 6 (2.94%) in CES with an emphasis in MHC, 33 (16.18%) in master's-level MFC/T, and 146 (71.57%) in master's-level MHC. Descriptive information about participants by current program enrollment is presented in Table 1.

Table 1

Demographic Data by Academic Program Subgroup

Factor	CES-MFC/T		CES-MHC		MFC/T-Masters		MHC-Masters	
	Frequency/%		Frequency/%		Frequency/%		Frequency/%	
Age								
20 –29	4	21.05	1	16.67	17	51.52	55	37.67
30 – 39	7	36.84	1	16.67	9	27.27	37	25.34
40 – 49	5	26.32	1	16.67	4	12.12	38	26.03
50 – 50+	3	15.79	3	50.00	3	9.09	16	10.96
Gender								
Female	13	68.42	4	66.67	26	78.79	114	78.08
Male	6	31.58	2	33.33	7	21.21	32	21.92
Program Accreditation								
CACREP	12	63.16	6	100.00	24	72.73	127	87.59
CACREP, APA	1	5.26	-	-----	3	9.09	14	9.66
CACREP, COAMFTE	6	31.58	-	-----	5	15.15	3	2.07
COAMFTE	-	-----	-	-----	1	3.03	-	-----
APA	-	-----	-	-----	-	-----	1	0.68
Missing	-	-----	-	-----	-	-----	1	-----
Clinical Experience Level								
None	1	5.56	-	-----	12	38.71	40	27.59
Practicum 1	-	-----	-	-----	5	16.13	16	11.03
Practicum 2	2	11.11	2	33.33	5	16.13	8	5.52
Masters-level Internship	-	-----	1	16.67	5	16.13	26	17.93
Completed all Masters-level	1	5.56	-	-----	4	12.90	55	37.93
Post-masters Clinical	1	5.56	1	16.67	-	-----	-	-----

Table 1 – Continued

Factor	CES-MFC/T Frequency/%		CES-MHC Frequency/%		MFC/T-Masters Frequency/%		MHC-Masters Frequency/%	
Doctoral-level Internship	3	16.67	-	-----	-	-----	-	-----
Completed all Masters & Doctoral-level	10	55.56	2	33.33	-	-----	-	-----
Missing	1	-----	-	-----	2	-----	1	-----
Primary Clinical Experience Setting								
MFC/T	17	89.47	-	-----	20	60.61	8	5.48
MHC	2	10.53	6	100.00	13	39.39	138	94.52
Trainees' Primary Organizational Affiliation								
AMHCA	-	-----	2	33.33	-	-----	29	20.00
ACES	6	31.58	3	50.00	-	-----	31	21.38
IAMFC	8	42.11	-	-----	11	33.33	4	2.76
None	5	26.32	1	16.67	22	66.67	81	55.86
Missing	-	-----	-	-----	-	-----	1	-----
Supervisor/Advisor/Instructor's Primary Professional Affiliation								
ACES with specialization in MFC/T	4	21.05	1	16.67	7	21.21	12	8.28
ACES with specialization in MHC	3	15.79	3	50.00	2	6.06	41	28.28
AMHCA	1	5.26	-	-----	3	9.09	33	22.76
IAMFC	4	21.05	-	-----	7	21.21	6	4.13
None	7	36.84	2	33.33	14	42.42	53	36.55
Missing	-	-----	-	-----	-	-----	1	-----
Total N	19	9.31	6	2.94	33	16.18	146	71.57

Response Rating Frequencies, Means and Standard Deviations
by Academic Program Type

As noted, program enrollment representation in this study was widely dispersed. Given the wide variability in the number of students who responded from the four possible programs, no participant responses were eliminated from the data analyses due to incomplete ratings on all 18 responses. Instead, response ratings were excluded from data analyses on a response-by-response evaluation of the data necessary to conduct any particular analysis related to the questions posed. The response means and standard deviations by type of academic program are summarized in Tables 2a – 2d. Response frequencies were computed for each of the 18 responses and for each of the four academic programs, and are presented in Table 3.

Table 2a

Means and Standard Deviations for Each Response by
Program: CES – Ph.D./Ed.D., MFC/T emphasis

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 1 – Systemic Dynamics	17	6.06	3.31
Vignette 1 – Content Focus	17	4.00	2.12
Vignette 1 – Linear Causality	17	5.41	2.87
Vignette 1 – Process Focus	16	6.81	2.71
Vignette 1 – Individual Dynamics	17	2.29	1.83
Vignette 1 – Circular Causality	18	7.56	2.67
Vignette 2 – Individual Dynamics	17	2.00	1.41
Vignette 2 – Linear Causality	17	3.94	2.22
Vignette 2 – Content Focus	17	5.76	2.44

Table 2a – CES – MFC/T emphasis continued

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 2 – Circular Causality	17	7.88	1.76
Vignette 2 – Systemic Dynamics	17	7.88	1.96
Vignette 2 – Process Focus	18	7.89	2.47
Vignette 3 – Individual Dynamics	16	6.06	2.41
Vignette 3 – Process Focus	16	6.44	2.22
Vignette 3 – Linear Causality	16	5.06	2.26
Vignette 3 – Circular Causality	16	6.31	2.89
Vignette 3 – Content Focus	16	5.19	2.43
Vignette 3 – Systemic Dynamics	17	8.06	2.19

The mean age of the 19 CES- emphasis MFC/T participants in this study was approximately 36 years. The range of experience level was from no clinical experience to completion of all master's- and doctoral-level experiences. The mean experience level was 6.61 years. Thus, the mean experience level reported was at the entry-level, doctoral experience in counseling (i.e., advanced clinical experience, post master's-level).

Table 2b

Means and Standard Deviations for Each Response by Program: CES – Ph.D./Ed.D., MHC emphasis

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 1 – Systemic Dynamics	4	3.25	1.26
Vignette 1 – Content Focus	6	6.83	2.56

Table 2b – CES – MHC emphasis continued

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 1 – Linear Causality	5	7.40	0.89
Vignette 1 – Process Focus	5	7.20	1.92
Vignette 1 – Individual Dynamics	5	3.40	1.67
Vignette 1 – Circular Causality	6	7.83	1.33
Vignette 2 – Individual Dynamics	6	3.50	3.15
Vignette 2 – Linear Causality	6	4.50	2.35
Vignette 2 – Content Focus	5	7.20	2.17
Vignette 2 – Circular Causality	6	7.00	2.97
Vignette 2 – Systemic Dynamics	6	4.67	3.39
Vignette 2 – Process Focus	6	6.50	1.22
Vignette 3 – Individual Dynamics	6	7.83	1.17
Vignette 3 – Process Focus	5	5.80	1.79
Vignette 3 – Linear Causality	6	7.17	1.72
Vignette 3 – Circular Causality	5	4.60	1.52
Vignette 3 – Content Focus	6	8.00	1.10
Vignette 3 – Systemic Dynamics	5	5.60	2.88

The mean age of the six CES-emphasis MHC participants in this study was approximately 41.67 years. The range of experience level was from Practicum 2 to completion of all master's- and doctoral-level experiences. The mean experience level

was 5.33 years. Thus, the mean experience level reported was at completion of all master's-level clinical experiences.

Table 2c

Means and Standard Deviations for Each Response by Program: MFC/T – Masters Level

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 1 – Systemic Dynamics	32	5.59	1.95
Vignette 1 – Content Focus	32	6.56	2.17
Vignette 1 – Linear Causality	32	6.69	2.22
Vignette 1 – Process Focus	32	6.28	2.19
Vignette 1 – Individual Dynamics	32	4.19	2.63
Vignette 1 – Circular Causality	32	6.72	2.07
Vignette 2 – Individual Dynamics	32	3.75	2.50
Vignette 2 – Linear Causality	32	4.88	2.80
Vignette 2 – Content Focus	32	7.06	2.37
Vignette 2 – Circular Causality	32	7.50	2.06
Vignette 2 – Systemic Dynamics	32	6.59	2.17
Vignette 2 – Process Focus	32	6.88	2.12
Vignette 3 – Individual Dynamics	32	6.41	2.31
Vignette 3 – Process Focus	32	6.63	2.39
Vignette 3 – Linear Causality	32	6.53	2.05
Vignette 3 – Circular Causality	32	5.47	2.18
Vignette 3 – Content Focus	32	6.63	2.11

Table 2c – MFC/T – Masters Level continued

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 3 – Systemic Dynamics	32	7.47	1.87

The mean age of the 33 MFC/T masters-level participants in this study was approximately 30.17 years. All experience level responses corresponded with the indicated academic degree of this subgroup. The mean experience level was 2.48 years. Thus, the mean experience level reported was at the Practicum 1 level.

Table 2d

Means and Standard Deviations for Each Response by Program: MHC – Masters Level

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 1 – Systemic Dynamics	145	5.10	2.23
Vignette 1 – Content Focus	143	5.89	2.26
Vignette 1 – Linear Causality	140	6.87	2.11
Vignette 1 – Process Focus	141	6.42	2.03
Vignette 1 – Individual Dynamics	141	4.47	2.42
Vignette 1 – Circular Causality	142	6.43	2.04
Vignette 2 – Individual Dynamics	139	3.85	2.37
Vignette 2 – Linear Causality	139	4.60	2.30
Vignette 2 – Content Focus	140	7.09	1.62
Vignette 2 – Circular Causality	140	7.56	1.93
Vignette 2 – Systemic Dynamics	142	6.37	2.40

Table 2d – MHC – Masters Level continued

Vignette/Response Type	N	Mean	Standard Deviation
Vignette 2 – Process Focus	142	6.57	2.37
Vignette 3 – Individual Dynamics	140	6.86	1.96
Vignette 3 – Process Focus	140	5.29	2.05
Vignette 3 – Linear Causality	140	6.31	2.11
Vignette 3 – Circular Causality	137	4.39	2.09
Vignette 3 – Content Focus	140	6.15	2.34
Vignette 3 – Systemic Dynamics	139	6.58	2.45

The mean age of the 146 MHC master's-level participants in this study was 33.67 years. The range of experience level was from Practicum 2 to completion of all master's-level clinical experiences. The mean experience level was 3.27 years. Thus, the mean experience level reported was at the Practicum 2 level.

Table 3

Response Frequencies by Academic Program

Vignette/Response Type Academic Program / Frequency/ Percent	Extremely Unlikely 1	2	3	4	5	6	7	8	9	Extremely Likely 10
V1 – Systemic Dynamics										
CES-MFC/T	2	2	2	-	1	-	1	3	5	1
	11.76	11.76	11.76		5.88		5.88	17.65	29.41	5.88
CES-MHC	-	1	2	-	1	-	-	-	-	-
		25.00	50.00		25.00					
MFC/T-Masters	-	3	4	2	3	7	8	5	-	-
		9.38	12.50	6.25	9.38	21.88	25.00	15.63		
MHC-Masters	5	12	27	24	10	18	23	21	3	2
	3.45	8.28	18.62	16.55	6.90	12.41	15.86	14.48	2.07	1.38

Table 3 – Response Frequencies by Academic Program continued

V1 – Content Focus										
CES-MFC/T	2	3	1	6	1	2	-	2	-	-
	11.76	17.65	5.88	35.29	5.88	11.76		11.76		
CES-MHC	-	1	-	-	-	1	-	3	1	-
		16.67				16.67		50.00	16.67	
MFC/T-Masters	-	1	2	5	3	2	4	8	7	-
		3.13	6.25	15.63	9.38	6.25	12.50	25.00	21.88	
MHC-Masters	4	7	14	21	12	17	26	28	10	4
	2.80	4.90	9.79	14.69	8.39	11.89	18.18	19.58	6.99	2.80
V1 – Linear Causality										
CES-MFC/T	1	2	3	2	-	1	5	-	1	2
	5.88	11.76	17.65	11.76		5.88	29.41		5.88	11.76
CES-MHC	-	-	-	-	-	1	1	3	-	-
						20.00	20.00	60.00		
MFC/T-Masters	-	2	1	4	3	2	3	11	5	1
		6.25	3.13	12.50	9.38	6.25	9.38	34.38	15.63	3.13
MHC-Masters	-	8	10	4	7	14	30	38	23	6
		5.71	7.14	2.86	5.00	10.00	21.43	27.14	16.43	4.29
V1 – Process Focus										
CES-MFC/T	1	-	1	1	1	4	1	2	1	4
	6.25		6.25	6.25	6.25	25.00	6.25	12.50	6.25	25.00
CES-MHC	-	-	-	1	-	-	1	2	1	-
				20.00			20.00	40.00	20.00	
MFC/T-Masters	-	1	3	5	4	1	5	9	3	1
		3.13	9.38	15.63	12.50	3.13	15.63	28.13	9.38	3.13
MHC-Masters	2	4	6	16	16	21	23	34	16	3
	1.42	2.84	4.26	11.35	11.35	14.89	16.31	21.11	11.35	2.13
V1 – Individual Dynamics										
CES-MFC/T	9	2	3	-	2	-	1	-	-	-
	52.94	11.76	17.65		11.76		5.88			
CES-MHC	-	2	1	1	-	1	-	-	-	-
		40.00	20.00	20.00		20.00				
MFC/T-Masters	3	8	7	2	3	2	-	4	3	-
	9.38	25.00	21.88	6.25	9.38	6.25		12.50	9.38	
MHC-Masters	14	22	23	20	14	12	17	11	6	2
	9.93	15.60	16.31	14.18	9.93	8.51	12.06	7.80	4.26	1.42
V1 – Circular Causality										
CES-MFC/T	1	1	-	-	1	1	3	3	3	5
	5.56	5.56			5.56	5.56	16.67	16.67	16.67	27.78

Table 3 – Response Frequencies by Academic Program continued

CES-MHC	-	-	-	-	-	-	4 66.67	-	1 16.67	1 16.67
MFC/T-Masters	1 3.13	-	-	5 15.63	4 12.50	1 3.13	7 21.88	8 25.00	5 15.63	1 3.13
MHC-Masters	-	5 3.52	12 8.45	12 8.45	12 8.45	22 15.49	31 21.83	28 19.72	14 9.86	6 4.23
V2 – Individual Dynamics										
CES-MFC/T	9 52.94	3 17.65	3 17.65	1 5.88	-	1 5.88	-	-	-	-
CES-MHC	2 33.33	2 33.33	-	-	-	-	1 16.67	1 16.67	-	-
MFC/T-Masters	6 18.75	6 18.75	9 28.13	1 3.13	1 3.13	2 6.25	3 9.38	3 9.38	1 3.13	-
MHC-Masters	23 16.55	26 18.71	30 21.58	12 8.63	9 6.47	16 11.51	11 7.91	5 3.60	6 4.32	1 0.72
V2 – Linear Causality										
CES-MFC/T	1 5.88	5 29.41	3 17.65	2 11.76	2 11.76	1 5.88	1 5.88	2 11.76	-	-
CES-MHC	1 16.67	-	1 16.67	1 16.67	1 16.67	-	2 33.33	-	-	-
MFC/T-Masters	2 6.25	6 18.75	7 21.88	2 6.25	2 6.25	2 6.25	2 6.25	5 15.63	3 9.38	1 3.13
MHC-Masters	10 7.19	18 12.95	28 20.14	18 12.95	14 10.07	16 11.51	15 10.79	15 10.79	4 2.88	1 0.72
V2 – Content Focus										
CES-MFC/T	-	1 5.88	4 25.53	1 5.88	2 11.76	1 5.88	3 17.65	2 11.76	3 17.65	-
CES-MHC	-	-	-	1 20.00	-	1 20.00	-	1 20.00	2 40.00	-
MFC/T-Masters	1 3.13	-	1 3.13	4 12.50	2 6.25	5 15.63	1 3.13	8 25.00	5 15.63	5 15.63
MHC-Masters	-	1 0.71	5 3.57	4 2.86	10 7.14	22 15.71	39 27.86	30 21.43	26 18.57	3 2.14
V2 – Circular Causality										
CES-MFC/T	-	-	1 5.88	-	-	1 5.88	5 29.71	3 17.65	4 23.53	3 17.65
CES-MHC	-	-	-	2 33.33	1 16.67	-	-	-	1 16.67	2 33.33
MFC/T-Masters	-	1 3.13	-	2 6.25	3 9.38	4 12.50	3 9.38	5 15.63	10 31.25	4 12.50

Table 3 – Response Frequencies by Academic Program continued

MHC-Masters	1	3	3	6	7	11	19	37	41	12
	0.71	2.14	2.14	4.29	5.00	7.86	13.57	26.43	29.29	8.57
V2 – Systemic Dynamics										
CES-MFC/T	-	1	-	-	-	2	2	5	4	3
		5.88				11.76	11.76	29.41	25.53	17.65
CES-MHC	2	-	1	-	-	-	1	2	-	-
	33.33		16.67				16.67	33.33		
MFC/T-Masters	1	1	1	2	3	5	8	5	4	2
	3.13	3.13	3.13	6.25	9.38	15.63	25.00	15.63	12.50	6.25
MHC-Masters	4	9	7	15	14	13	23	31	18.57	10
	2.82	6.34	4.93	10.56	9.86	9.15	16.20	21.83		7.04
V2 – Process Focus										
CES-MFC/T	-	2	-	-	-	1	2	5	2	6
		11.11				5.56	11.11	27.78	11.11	33.33
CES-MHC	-	-	-	1	-	-	5	-	-	-
				16.67			83.33			
MFC/T-Masters	-	-	3	3	2	3	8	6	3	4
			9.38	9.38	6.25	15.63	25.00	18.75	9.38	12.50
MHC-Masters	2	5	13	16	8	12	29	22	23	12
	1.41	3.52	9.15	11.27	5.63	8.45	20.42	15.49	16.20	8.45
V3 – Individual Dynamics										
CES-MFC/T	-	2	2	1	-	1	4	5	1	-
		12.50	12.50	6.25		6.25	25.00	31.25	6.25	
CES-MHC	-	-	-	-	-	-	3	2	-	1
							50.00	33.33		16.67
MFC/T-Masters	-	1	5	1	4	4	5	5	5	2
		3.13	15.63	3.13	12.50	12.50	15.63	15.63	15.63	6.25
MHC-Masters	1	3	7	8	10	23	28	29	26	5
	0.71	2.14	5.00	5.71	7.14	16.43	20.00	20.71	18.57	3.57
V3 – Process Focus										
CES-MFC/T	-	-	2	3	-	2	2	5	1	1
			12.50	18.75		12.50	12.50	31.25	6.25	6.25
CES-MHC	-	-	-	2	-	1	1	1	-	-
				40.00		20.00	20.00	20.00		
MFC/T-Masters	1	-	1	6	3	5	2	4	7	3
	3.13		3.13	18.75	9.38	15.63	6.25	12.50	21.88	9.38
MHC-Masters	2	14	12	26	20	22	20	17	7	-
	1.43	10.00	8.57	18.57	14.29	15.71	14.29	12.14	5.00	

Table 3 – Response Frequencies by Academic Program continued

V3 – Linear Causality										
CES-MFC/T	1 6.25	-	5 31.25	2 12.50	-	1 6.25	5 31.25	2 12.50	-	-
CES-MHC	-	-	-	1 16.67	-	-	2 33.33	2 33.33	1 16.67	-
MFC/T-Masters	-	-	3 9.38	4 12.50	3 12.50	4 12.50	7 21.88	4 12.50	6 18.75	1 3.13
MHC-Masters	1 0.71	2 1.43	17 12.14	16 11.43	10 7.14	20 14.29	22 15.71	31 22.14	19 13.57	2 1.43
V3 – Circular Causality										
CES-MFC/T	1 6.25	3 18.75	-	-	1 6.25	-	2 12.50	6 37.50	3 18.75	-
CES-MHC	-	-	1 20.00	2 40.00	1 20.00	-	1 20.00	-	-	-
MFC/T-Masters	-	3 9.38	5 15.63	4 12.50	3 9.38	5 15.63	6 18.75	3 9.38	3 9.38	-
MHC-Masters	8 5.84	21 15.33	25 18.25	23 16.79	18 13.14	14 10.22	15 10.95	11 8.03	2 1.46	-
V3 – Content Focus										
CES-MFC/T	-	4 25.00	-	2 12.50	3 18.75	2 12.50	2 12.50	1 6.25	2 12.50	-
CES-MHC	-	-	-	-	-	-	2 33.33	3 50.00	-	1 16.67
MFC/T-Masters	-	1 3.13	2 6.25	5 15.63	1 3.13	3 9.38	5 15.63	9 28.13	6 18.75	-
MHC-Masters	6 4.29	6 4.29	13 9.29	13 9.29	7 5.00	19 13.57	30 21.43	23 16.43	21 15.00	2 1.43
V3 – Systemic Dynamics										
CES-MFC/T	-	-	-	2 11.76	1 5.88	1 5.88	2 11.76	2 11.76	2 11.76	7 41.18
CES-MHC	-	1 20.00	-	1 20.00	1 20.00	-	-	1 20.00	1 20.00	-
MFC/T-Masters	-	-	1 3.13	2 6.25	2 6.25	4 12.50	5 15.63	6 18.75	9 28.13	3 9.38
MHC-Masters	3 2.16	4 2.88	14 10.07	13 9.35	12 8.63	11 7.91	23 16.55	23 16.55	21 15.11	15 10.79

Intercorrelations

Patterns of responding within each academic subgroup (i.e., CES-MFC/T emphasis, CES-MHC emphasis, MFC/T – master's-level, and MHC – master's-level) were examined by use of an 18-item intercorrelation matrix. Tables 4a – 4d present the statistically significant correlations for each of six possible response types for vignettes one to three. Each table presents data for a different academic subgroup. The response type (i.e., conceptual dimension) is indicated by the corresponding vignette and response.

Table 4a presents the statistically significant correlations of Vignette 1, 2, 3 and V1, V2, and V3 for students currently enrolled in a CES – MFC/T emphasis program. Across the three vignettes, some significant positive correlations between the same response types and response types associated with a particular specialization (i.e., MFC/T or MHC) were found. However, several significant positive correlations between different specializations also were found between Vignette 1 and 2 (i.e., Systemic-MFC/T and Individual-MHC), Vignette 1 and 3 (i.e., Content-MHC and Process-MFC/T), Vignette 2 and 3 (i.e., Linear-MHC and Process-MFC/T), and between response types in Vignette 3 (i.e., Content-MHC and Systemic-MFC/T). The latter two of these findings across area of specialization (i.e., MFC/T or MHC) represent positive, statistically significant correlations across one of the three previously defined key conceptual disciplinary dimensions (i.e., Individual vs. systemic dynamics, Linear vs. Circular causality, and Content vs. Process focus).

Table 4a. Intercorrelations Among Dependent Variables for Vignettes 1, 2 and 3, and V1, V2, and V3 by Program: CES – Ph.D./Ed.D. MFC/T emphasis

*.p< .05 **.p< .01

VARIABLES	V1-Sys	V1-Cnt	V1-Lin	V1-Prc	V1-Indv	V1-Crl	V2-Indv	V2-Lin	V2-Cnt	V2-Crl	V2-Sys	V2-Prc	V3-Indv	V3-Prc	V3-Lin	V3-Crl	V3-Cnt	V3-Sys
Vignette 1 Systemic	-		-0.707*	0.508*			0.590*		-0.510*				-0.549*		-0.566*			
Vignette 1 Content		-			0.644**		0.521*							0.581*				
Vignette 1 Linear			-	-0.563*					0.514*						0.742**			
Vignette 1 Process				-		0.614*								0.692**				
Vignette 1 Individual					-		0.604*											
Vignette 1 Circular						-								0.595*				
Vignette 2 Individual							-							0.534*				
Vignette 2 Linear								-	0.736**					0.532*				
Vignette 2 Content									-				0.830**		0.765**			
Vignette 2 Circular										-	0.862*							
Vignette 2 Systemic											-	0.484*				0.597*		
Vignette 2 Process												-				0.652**		0.612**
Vignette 3 Individual													-		0.770**			
Vignette 3 Process														-				
Vignette 3 Linear															-			
Vignette 3 Circular																-		0.681**
Vignette 3 Content																	-	0.509*
Vignette 3 Systemic																		-

Presented in Table 4b are the statistically significant correlations of Vignette 1, 2, 3 and V1, V2, and V3 for CES – MHC emphasis students. Statistically significant, positive correlations among like response types were found between Vignette 1-Process and V2-Process, Vignette 2-Individual and V3-Individual, Vignette 2-Linear and V3-Linear. Several statistically significant, negative correlations also were found between responses within a vignette (i.e., Vignette 1-Linear and V1-Individual, Vignette 2-Individual and V2-Content, and Vignette 3-Linear and V3-Content). These negative correlations indicate that the six participating CES-MHC emphasis students' responses tended to increase and decrease within the MHC specialization, based on different conceptual dimensions. The same type of relationship (i.e., negative correlation between conceptual dimensions within a single area of specialization) occurred between Vignette 2-Linear and V3-Content.

Table 4c presents the correlations between dependent variables for students currently pursuing a master's-level degree in MFC/T. In addition to statistically significant, positive correlations between same response types and between response types within a particular specialization, there were statistically significant, negative correlations between conceptual dimensions for different specializations. For example, Vignette 2-Individual was significantly, negatively correlated to V2-Systemic while Vignette 2-Process was significantly, negatively correlated with the Individual and Content responses of V3. Statistically significant correlations between unlike responses from different academic specializations also were found. The systemic response and the individual response in Vignette 1 were positively correlated. The individual response in Vignette 1 was positively correlated with the circular response in Vignette 3.

Table 4b. Intercorrelations Among Dependent Variables for Vignette 1, 2 and 3, and V1, V2, and V3 by Program: CES – Ph.D./Ed.D. MHC emphasis

*.p < .05 **.p < .01

VARIABLES	V1-Sys	V1-Cnt	V1-Lin	V1-Prc	V1-Indv	V1-Crl	V2-Indv	V2-Lin	V2-Cnt	V2-Crl	V2-Sys	V2-Prc	V3-Indv	V3-Prc	V3-Lin	V3-Crl	V3-Cnt	V3-Sys
Vignette 1 Systemic	-																	
Vignette 1 Content		-																
Vignette 1 Linear			-		-0.969**										·			
Vignette 1 Process				-								0.930*						
Vignette 1 Individual					-													
Vignette 1 Circular						-											0.824*	
Vignette 2 Individual							-		-0.925*				0.843*					
Vignette 2 Linear								-							0.817*		-0.934**	
Vignette 2 Content									-	·								
Vignette 2 Circular										-								
Vignette 2 Systemic											-							
Vignette 2 Process												-	-0.908*					
Vignette 3 Individual													-					
Vignette 3 Process										·				-				
Vignette 3 Linear															-		-0.848*	
Vignette 3 Circular																-		
Vignette 3 Content																	-	
Vignette 3 Systemic																		-

Table 4c. Intercorrelations Among Dependent Variables for Vignette 1, 2 and 3, and V1, V2, and V3 by Program: MFC/T – Masters Level

*.p < .05 **.p < .01

VARIABLES	V1-Sys	V1-Cnt	V1-Lin	V1-Prc	V1-Indv	V1-Crl	V2-Indv	V2-Lin	V2-Cnt	V2-Crl	V2-Sys	V2-Prc	V3-Indv	V3-Prc	V3-Lin	V3-Crl	V3-Cnt	V3-Sys
Vignette 1 Systemic	-			0.436*	0.393*	0.715**												0.391*
Vignette 1 Content		-															0.704**	
Vignette 1 Linear			-				-0.363*											
Vignette 1 Process				-		0.396*					0.453**							
Vignette 1 Individual					-		0.463**								0.394*	0.371*		
Vignette 1 Circular						-												0.512**
Vignette 2 Individual							-	0.437*			-0.561**							
Vignette 2 Linear								-									0.353*	-0.482**
Vignette 2 Content									-									
Vignette 2 Circular										-	0.393*	0.383*		0.634**				0.557**
Vignette 2 Systemic											-	0. 480**				0.409*	-0.366*	
Vignette 2 Process												-	-0.463**	0.365*			-0.350*	
Vignette 3 Individual													-					
Vignette 3 Process														-		0.430*		0.546**
Vignette 3 Linear															-			
Vignette 3 Circular																-		
Vignette 3 Content																	-	
Vignette 3 Systemic																		-

Table 4d. Intercorrelations Among Dependent Variables for Vignette 1, 2 and 3, and V1, V2, and V3 by Program: MHC – Masters Level

*.p < .05 **.p < .01

VARIABLES	V1-Sys	V1-Cnt	V1-Lin	V1-Prc	V1-Indv	V1-Crl	V2-Indv	V2-Lin	V2-Cnt	V2-Crl	V2-Sys	V2-Prc	V3-Indv	V3-Prc	V3-Lin	V3-Crl	V3-Cnt	V3-Sys
Vignette 1 Systemic	-			0.195*	0.195*	0.309**					0.196*	0.178*		0.285**		0.301**		
Vignette 1 Content		-	0.222**				0.203*								0.298**		0.361**	
Vignette 1 Linear			-											-0.188*	0.344**		0.365**	
Vignette 1 Process				-	0.243**	0.308**				0.415**	0.267**	0.278**						0.201*
Vignette 1 Individual					-	0.212*		0.265**			0.307**	0.316**		0.195*	0.264**	0.181*		0.228**
Vignette 1 Circular						-				0.282**	0.363**	0.296**		0.270**	0.196*	0.329**		0.366**
Vignette 2 Individual							-	0.358**		-0.364**			0.223**		0.244**	0.175*		
Vignette 2 Linear								-			0.251**		0.207*	0.259**	0.319**	0.278**	0.333**	0.180**
Vignette 2 Content									-									
Vignette 2 Circular										-	0.312**	0.307**						0.357**
Vignette 2 Systemic											-	0.542**		0.268**		0.232**		0.404**
Vignette 2 Process												-		0.309**		0.235**		0.294**
Vignette 3 Individual													-					
Vignette 3 Process														-		0.484**		0.303**
Vignette 3 Linear															-		0.382**	
Vignette 3 Circular																-	0.229**	0.322**
Vignette 3 Content																	-	
Vignette 3 Systemic																		-

Table 4d presents statistically significant correlations among those respondents currently enrolled in a master's-level MHC program. As in the other academic subgroups, statistically significant, positive correlations were found between like conceptual dimensions and among various dimensions within a given specialization and across all three vignettes. For example, Vignette 1-Systemic was significantly and positively correlated to V1-Process, V1-Circular, V2-Systemic, V2-Process, V3-Process, and V3-Circular. Similarly, statistically significant, positive correlations were found between Vignette 2-Individual and V2-Linear, V3-Individual, and V3-Linear, among others. In addition, significant, positive correlations were found between specializations as well as between conceptual dimensions associated with differing areas of academic study. These relationships occurred as fifteen different dependent variable intercorrelations, across all three vignettes, and between responses within each vignette.

Analyses by Hypothesis

All hypotheses were analyzed for each of the three vignettes and the six response types within each vignette. The probability level for rejection of an hypothesis was $p = .05$ for all tests. The rejection criterion was that at least one-half of the survey response means had to have differences of statistical significance. Appendix M reports the response means for all hypotheses.

Ho1: There is no difference in trainees' conceptualization ratings based on age category.

A factorial ANOVA revealed no significant differences in response preferences across age categories for five of the six responses for each of the three vignettes. Based on these results, this hypothesis was not rejected. However, the following significant

differences were found for Vignette 1: Response 2 (V1/R2), for Vignette 2: Response 1 (V2/R1), and for Vignette 3: Response 2 (V3/R2), which corresponded to statistically significant differences for content focus, individual dynamic, and process focus response preferences respectively. Therefore, the Tukey's Studentized Range (HSD) *post hoc* analysis was used as a multiple-comparison analysis to determine the pattern of significant differences. These comparisons are reported in Table 6.

Significant differences in the means between the 20-29 years and the 40-49 years age categories of V1/R2 were found. The younger group of trainees had the significantly higher mean. A statistically significant difference between the mean of 20-29 years and the 40-49 years age groups also occurred in the process focus conceptualization response reflected in V3/R2. The statistically significant mean difference for the individual dynamic conceptualization response of V2/R1 was found between 20-29 years and 50+ years of age groups. Again, the younger respondents had the statistically significant higher mean.

Table 5

Analysis of Variance Summary for Student Age

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R2 - Content	3	66.8979	22.2993	4.39	0.0051*
V2/R1 – Individual	3	56.4072	18.8024	3.35	0.0200*
V3/R2 – Process	3	41.7366	13.9122	3.04	0.0303*

*.p < .05

Table 6

Tukey's HSD Analysis for Student Age

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V1/R2 – Content Focus			
(20-29) – (40-49)	1.3311	0.2547	2.4076
V2/R1 – Individual Dynamic			
(20-29) – (50+)	1.6933	0.2765	3.1102
V3/R2 – Process Focus			
(20-29) – (40-49)	1.0984	0.0664	2.1305

Comparisons significant at the 0.05 level

Ho2: There is no relationship between ratings of conceptualization and the number of practica and/or internships trainees have completed.

The magnitude and direction of the relationship between conceptualization ratings and the number of practica and/or internships trainees have completed was tested by the Spearman Rho correlational coefficient. For all but three responses, no statistically significant relationships were found between the variables. Therefore, this hypothesis was not rejected. However, statistically significant correlations were found for the content focus responses of Vignettes one and three and the Individual dynamic response of Vignette one. All conceptual dimensions with a statistically significant relationship are commonly associated with the MHC specialty. There was only a slight negative relationship between the number of practica/internships trainees have completed and conceptualization ratings.

Table 7

Spearman Rho Correlational Coefficients

V/R – Conceptual Dimension	Spearman's CC	Prob > |r| under Ho : Rho 0
V1/R2 – Content Focus	-0.2342	0.0008*
V1/R5 – Individual Dynamic	-0.2046	0.0035*
V3/R5 – Content Focus	-0.1410	0.0459*

*.p < .05

Ho3: There is no difference in trainees' conceptualization ratings based on gender.

The student's *t test* was used to determine if there was a statistically significant difference between the 18 response means based on gender. No statistically significant *t* values were found. Therefore, this hypothesis was not rejected.

Ho4: There is no difference in trainees' conceptualization ratings based on academic major (i.e., professional specialization).

No significant differences in response preferences across academic major were revealed for the following vignettes and responses: Vignette 1: R1, R3, R4, R6, Vignette 2: R2, R4, R6, and Vignette 3: R1, R3, R5, and R6. However, as shown in Table 8, statistically significant differences were found for V1/R2 (Content Focus), V1/R5 (Individual Dynamic), V2/R1 (Individual Dynamic), V2/R3 (Content Focus), V2/R5 (Systemic Dynamic), V3/R2 (Process Focus), and V3/R4 (Circular Causality). Given that only 38.89% of the responses were statistically significantly different, this hypothesis was not rejected.

Table 8

Analysis of Variance Summary for Student Academic Major (Professional Specialization)

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R2 - Content	3	80.40	26.80	5.33	0.0015*
V1/R5 – Individual	3	75.08	25.03	4.35	0.0054*
V2/R1 – Individual	3	52.22	17.41	3.15	0.0263*
V2/R3 – Content	3	27.11	9.04	2.64	0.0500*
V2/R5 – Systemic	3	55.41	18.47	3.31	0.0213*
V3/R2 – Process	3	58.16	19.39	4.30	0.0058*
V3/R4 – Circular	3	73.04	24.35	5.16	0.0019*

*.p < .05

Table 9

Tukey's HSD Analysis for Student Academic Major (Professional Specialization)

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V1/R2 – Content Focus			
(CES-MHC)–(CES-MFC/T)	2.8333	0.0747	5.5919
(MFC/T) – (CES-MFC/T)	2.5625	0.8190	4.3060
(MHC) – (CES-MFC/T)	1.8881	0.3977	3.3785
V1/R5 – Individual Dynamic			
(MHC) – (CES-MFC/T)	2.1740	0.5780	3.7699
(MFC/T) – (CES-MFC/T)	1.8934	0.0277	3.7590
V2/R1 – Individual Dynamic			
(MHC) – (CES-MFC/T)	1.8489	0.2824	3.4155
V2/R3 – Content Focus			
(MHC) – (CES-MFC/T)	1.3210	0.0890	2.5530

Table 9 – Continued

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V2/R5 – Systemic Dynamic (CES-MFC/T)–(CES-MHC)	3.2157	0.3076	6.1238
V3/R2 – Process Focus (MFC/T) – (MHC)	1.3321	0.2543	2.4100
V3/R4 – Circular Causality (CES-MFC/T) – (MHC)	1.9183	0.4308	3.4058

Comparisons significant at the 0.05 level

Table 9 reports the specific subgroup comparisons for statistically significant mean differences. For example, doctoral-level students emphasizing MFC/T had a higher mean response for the Systemic Dynamic conceptual dimension of V2/R5 than did doctoral-level students emphasizing MHC in their academic studies. The relationship between the two academic specializations at the doctoral-level of study was reversed for the Content Focus conceptual dimension of V1/R2. Additional differences between the means based on the four academic majors/professional specializations (i.e., MFC/T, MHC, CES-MFC/T, and CES-MHC) are shown in Table 9. All statistically significant subgroup comparisons are to be read left to right, from highest to lowest subgroup mean. Thus, (CES-MFC/T) – (MHC) is interpreted as doctoral-level students emphasizing MFC/T having a higher mean than masters level students in MHC, for V3/R4 (Circular Causality conceptual dimension).

A methodological footnote is important to note. This study utilized the Tukey's HSD *a posteriori* multiple-comparison procedure because of its ability to control for Type 1 experimentwise error rate. This led to a smaller number of significant differences

than most other *post hoc* analyses. In addition, Type III SS reporting accounts for unequal cell size comparisons throughout this study (Ferguson, 1989). These analyses did not corroborate the differences found by the ANOVA. That is, when Tukey's HSD was conducted on V3/R5 and V3/R6, no subgroup comparisons were found to be statistically significantly different. A less rigorous test, Duncan's Multiple Range Test, therefore was used to assess V3/R5 and V3/R6 further. Duncan's MRT did reveal statistically significant differences between subgroup means. It should be noted, however, that the Duncan's MRT does not control for Type 1 error, is less rigorous, and is methodologically inconsistent with the analyses determined most appropriate for this study.

Ho4a: There are no significant interaction effects among age category and academic major (i.e., professional specialization).

Based on the data for the factorial ANOVA (4 x 4), this hypothesis was not rejected. However, the data in Table10 show that a significant interaction effect was found for age category and academic major for the content focus and individual dynamics responses of Vignette 1, the second vignette's individual and systemic dynamics and content focus responses, and the process focus, linear causality, and circular causality responses of Vignette 3.

Table10

Analysis of Variance Summary for Age by Academic Major (Professional Specialization)

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R2 – Content	15	215.87	14.39	3.12	0.0001*
V1/R5 – Individual	15	168.99	11.27	1.94	0.0215*
V2/R1 – Individual	15	157.75	10.52	1.94	0.0219*
V2/R3 – Content	15	102.38	6.83	2.02	0.0158*
V2/R5 – Systemic	15	149.80	9.99	1.87	0.0288*
V3/R2 - Process	15	135.07	9.00	2.06	0.0138*
V3/R3 – Linear	15	164.70	10.98	2.62	0.0013*
V3/R4 - Circular	15	201.77	13.45	2.93	0.0004*

*.$p < .05$

Ho4b: There are no significant interaction effects among trainees' gender and academic major (i.e., professional specialization).

The factorial ANOVA revealed no significant interaction effects for gender and academic major. Therefore, this hypothesis was not rejected.

Ho5: There is no difference in trainees' conceptualization ratings based on academic program level.

This hypothesis was rejected for ten of the eighteen responses (see Table 11). A statistically significant difference was found for the individual dynamic response across all three vignettes based on trainees' academic program level. Additional statistically significant response mean differences based on academic program level (e.g., master's or doctoral-level experience) were found for the content focus response of V1 and V2, the

linear causality response of V1 and V3, the systemic dynamic response of V2 and V3, and the circular causality response of V3.

Table 11

Analysis of Variance Summary for Student Academic Program Level

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R2 - Content	1	56.46	56.50	11.12	0.0010*
V1/R3 – Linear	1	28.80	28.79	5.95	0.0156*
V1/R5 – Individual	1	82.17	82.17	14.11	0.0002*
V2/R1 – Individual	1	47.58	47.58	8.51	0.0039*
V2/R3 – Content	1	33.37	33.37	9.57	0.0023*
V2/R5 – Systemic	1	26.39	26.39	4.72	0.0310*
V3/R1 – Individual	1	42.81	42.81	10.05	0.0018*
V3/R3 – Linear	1	44.38	44.38	9.87	0.0019*
V3/R4 – Circular	1	51.32	51.32	10.20	0.0016*
V3/R6 – Systemic	1	31.32	31.32	5.67	0.0182*

*.$p < .05$

The Tukey HSD analysis (see Table 12) shows that for all responses associated with a MHC specialty, the mean for master's-level students was higher than the mean for doctoral-level students. Conversely, for all MFC/T specialty conceptually associated responses, the mean for master's-level students was lower than the mean for doctoral-level trainees.

Table 12

Tukey's HSD Analysis for Student Academic Program Level

V/R – Conceptual Dimension Comparison	Mean (Masters-level)	Mean (Doctoral-level)
V1/R2 – Content Focus	6.0217	4.2105
V1/R3 – Linear Causality	6.8197	5.5263
V1/R5 – Individual Dynamic	4.4481	2.2632
V2/R1 – Individual Dynamic	3.8736	2.2105
V2/R3 – Content Focus	7.0765	5.6842
V2/R5 – Systemic Dynamic	6.3934	7.6316
V3/R1 – Individual Dynamic	6.8407	5.2632
V3/R3 – Linear Causality	6.3956	4.7895
V3/R4 – Circular Causality	4.6409	6.3684
V3/R6 – Systemic Dynamic	6.7033	8.0526

Comparisons significant at the 0.05 level

Ho6: There is no difference in trainees' conceptualization ratings based on their professional affiliation.

Twelve of the eighteen student response means were not significantly different based on students' reported professional affiliation. Therefore, this null hypothesis was not rejected. However, statistically significant differences were found based on students' professional affiliation in the individual dynamic response of Vignette 1 and Vignette 3, and the process focus and circular causality responses of Vignette 3 (see Table 13).

Table 13

Analysis of Variance Summary for Student Professional Affiliation

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R5 - Individual	3	62.51	20.84	3.58	0.0149*
V3/R1 – Individual	3	46.58	15.53	3.85	0.0105*
V3/R2 – Process	3	42.16	14.05	3.06	0.0294*
V3/R4 – Circular	3	99.33	33.11	7.24	0.0001*

*.$p < .05$

Table 14 shows the specific professional affiliation subgroup comparisons that had statistically significant differences. For example, students reporting an IAMFC professional affiliation had a higher mean response to V3/R4 (Circular Causality conceptual dimension) than students reporting an ACES, an AMHCA, or no professional affiliation. Similarly, in regard to V3/R2 (Process Focus), students with a reported IAMFC professional affiliation responded with a higher mean than did students with an ACES or an AMHCA affiliation. Referring to the individual dynamic responses of Vignette one and three, respectively, students with an AMHCA professional affiliation had a higher mean response than those reporting an ACES affiliation for V1 and AMHCA affiliated students had a higher mean response than students with either no or an IAMFC professional affiliation for V3.

Table 14

Tukey's HSD Analysis for Student Professional Affiliation

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V1/R5 – Individual Dynamic			
AMHCA - ACES	1.89	0.3350	3.4459
V3/R1 – Individual Dynamic			
AMHCA – None	1.08	0.0204	2.1457
AMHCA – IAMFC	1.76	0.3321	3.1966
V3/R2 – Process Focus			
IAMFC – ACES	1.57	0.0773	3.0581
IAMFC – AMHCA	1.57	0.0336	3.1113
V3/R4 – Circular Causality			
IAMFC – ACES	1.83	0.3071	3.3596
IAMFC – AMHCA	2.18	0.6253	3.7383
IAMFC – None	2.31	1.0102	3.6106

Comparisons significant at the 0.05 level

Ho7: There is no difference in trainees' conceptualization ratings based on type of program accreditation.

The data collected included five possible program accreditation categories: CACREP only, CACREP and APA, CACREP and COAMFTE, APA only, and COAMFTE only. However, the latter two categories were not testable because only one participant identified in each of these categories. Therefore, three categories of possible program accreditation were used.

Statistically significant differences in response means based on trainees' program accreditation were found for the Individual dynamic response of Vignette 1 and the Process focus response of Vignette 2. However, no statistically significant differences

were found among the remaining sixteen responses. Therefore, this hypothesis was not rejected.

Table 15 summarizes the statistically significance difference based on the type of program accreditation. The Tukey HSD *a posteriori* multiple-comparison procedure is detailed in Table 16. It showed that the Individual Dynamic response (V1/R5) mean for trainees in programs accredited by CACREP and APA was higher than the mean for trainees in programs with CACREP and COAMFTE accreditation. For the Process Focus response of V2/R6, trainees in programs accredited by both CACREP and COAMFTE had a higher mean than the mean of trainees in programs with only CACREP accreditation.

Table15

Analysis of Variance Summary for Trainees' Program Accreditation Type

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R5 - Individual	2	43.53	21.76	3.69	0.0267*
V2/R6 – Process	2	37.24	18.62	3.52	0.0314*

*.p < .05

Table 16

Post Hoc (Tukey's HSD) Analysis for Trainees' Program Accreditation Type

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V1/R5 – Individual Dynamic			
(CACREP, APA) – (CACREP, COAMFTE)	2.3846	0.2723	4.4969
V2/R6 – Process Focus			
(CACREP, COAMFTE) – (CACREP)	1.6506	0.1392	3.1621

Comparisons significant at the 0.05 level

Ho8: There is no difference in trainees' conceptualization ratings based on primary type of practica and/or internship experience.

Statistically significant differences were found for the systemic dynamic, individual dynamic, and linear causality response types of Vignette 1 and also for Vignette 3 for the individual dynamic, process focus, and circular causality responses. However, statistically significant differences were not found for the other 12 response types. Based on the majority decision rule, this hypothesis was not rejected.

Table 17

Analysis of Variance Summary for Trainees' Primary Practica/Internship Setting

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R1 - Systemic	1	21.30	21.30	4.07	0.0450*
V1/R3 – Linear	1	30.06	30.06	6.33	0.0127*
V1/R5 – Individual	1	64.90	64.90	11.30	0.0009*
V3/R1 – Individual	1	27.14	27.14	6.63	0.0108*
V3/R2 – Process	1	46.13	46.13	10.21	0.0016*
V3/R4 – Circular	1	41.35	41.35	8.55	0.0039*

*.$p < .05$

The Tukey's HSD analysis showed that the mean for students with primary practica/internship experience in a MFC/T setting was higher than the mean for students primarily having practica/internship experience in a MHC setting for responses conceptually associated with a MFC/T counseling specialization (e.g., systemic dynamic, process focus, or circular causality). For example, for V1/R1 (Systemic Dynamic), students having primary MFC/T setting practica/internship experience had a higher mean

than those students with primary clinical experience in a MHC setting. Similarly, students experiencing primary clinical work in a MHC setting had higher means on responses conceptually associated with the MHC specialty, than did those students with MFC/T primary practica/internship setting experience. Tables 18 and 19 report these significant differences in the means according to counseling specialty conceptual association.

Table 18

Tukey's HSD Analysis for Trainees' Primary Practica/Internship Setting by MFC/T Counseling Specialty Conceptual Dimension

V/R – Conceptual Dimension Comparison	Mean (MFC/T setting)	Mean (MHC setting)
V1/R1 – Systemic Dynamic	5.8409	5.0519
V3/R2 – Process Focus	6.5349	5.3600
V3/R4 – Circular Causality	5.6047	4.4898

Comparisons significant at the 0.05 level

Table 19

Tukey's HSD Analysis for Trainees' Primary Practica/Internship Setting by MHC Counseling Specialty Conceptual Dimension

V/R – Conceptual Dimension Comparison	Mean (MFC/T setting)	Mean (MHC setting)
V1/R3 – Linear Causality	6.0000	6.9400
V1/R5 – Individual Dynamics	3.1364	4.5166
V3/R1 – Individual Dynamics	6.0465	6.9470

Comparisons significant at the 0.05 level

Ho8a: There are no significant interaction effects among the number of practica and/or internships trainees completed and the primary type of practica and/or internship experience.

Based on the data in Table 20, this hypothesis was not rejected. For thirteen of the eighteen responses, there were no statistically significant interaction effects. However, Table 20 shows that a significant interaction effect was found for amount and type of practica/internships for the three MHC conceptual dimensions of Vignette 1, and the Individual dynamics and Content focus responses of Vignette 3.

Table 20

Analysis of Variance Summary for Number of Practica/Internships Trainees have Completed by Primary Type of Trainees' Practica/Internships Experience

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R2 - Content	15	154.38	10.29	2.08	0.0123*
V1/R3 – Linear	15	141.12	9.41	2.05	0.0144*
V1/R5 - Individual	15	188.40	12.56	2.21	0.0075*
V3/R1 – Individual	15	133.62	8.91	2.18	0.0085*
V3/R5 - Content	15	133.37	8.89	1.75	0.0441*

*.$p < .05$

Ho9: There is no difference in trainees' conceptualization ratings based on professional affiliation of their respective primary supervisor/educator/instructor.

Statistically significant differences in the means were found for only six of the eighteen responses based on professional orientation of trainees' primary supervisor/educator/instructor Only four of these six findings were supported by Tukey's

HSD *post hoc* analysis. Therefore, this hypothesis was not rejected. Table 21 presents the statistically significant results.

Table 21

Analysis of Variance Summary for Professional Affiliation of Trainees' Respective Primary Supervisor/Educator/Instructor

V/R-Conceptualization	DF	Type III SS	MS	F	Pr>F
V1/R3 - Linear	4	59.77	14.94	3.18	0.0147*
V1/R6 – Circular	4	43.12	10.78	2.48	0.0452*
V2/R5 – Systemic	4	65.68	16.42	2.99	0.0201*
V2/R6 – Process	4	85.49	21.37	4.18	0.0029*

*.p < .05

Table 22 presents Tukey's HSD *post hoc* analysis. Regarding V1/R3 (Linear Causality), students who identified their primary supervisor's professional affiliation as ACES with an emphasis in MFC/T (ACES-MFC/T) had a higher mean response than those who identified their primary educator's professional affiliation as "none" or as IAMFC. For the Circular Causality conceptual response of Vignette 1, instructor's primary affiliation with IAMFC found their respective students' response mean to be higher than the response mean of students identifying their respective primary supervisor's with ACES and an emphasis in MHC (ACES-MHC). Trainees' identifying supervisors as primarily associated with IAMFC had a higher response mean on the Process Focus conceptual response of Vignette 2 than students identifying their respective primary educator's professional affiliation with either AMHCA or ACES-MHC. IAMFC professional affiliation of a trainees' primary supervisor/educator was identified again as having a higher response mean for the Process Focus of Vignette 2

than ACES-MHC or AMHCA, or no primary professional affiliation of student's respective supervisor/instructor.

Table 22

Tukey's HSD Analysis for Professional Affiliation of Trainees' Respective Primary Supervisor/Educator/Instructor

V/R – Conceptual Dimension Comparison	Mean Differences	Simultaneous 95% Confidence Limits	
V1/R3 – Linear Causality			
(ACES-MFC/T) – (None)	1.47	0.0357	2.9046
(ACES-MFC/T) – (IAMFC)	1.91	0.0041	3.8220
V1/R6 – Circular Causality			
(IAMFC) – (ACES-MHC)	1.79	0.1683	3.4162
V2/R5 – Process Focus			
(IAMFC) – (AMHCA)	1.90	0.0045	3.7983
(IAMFC) – (ACES-MHC)	2.27	0.4343	4.0989
V2/R6 – Process Focus			
(IAMFC) – (ACES-MHC)	1.82	0.0527	3.5794
(IAMFC) – (None)	1.94	0.2595	3.6196
(IAMFC) – (AMHCA)	2.30	0.4781	4.1292

Comparisons significant at the 0.05 level

Summary

Only one hypothesis posited by this study was rejected, based on the majority rule. The hypothesis rejected was that there is no difference in trainees' conceptualization ratings based on academic program level.

CHAPTER 5
DISCUSSION

Mental health counseling and marriage and family counseling/therapy are two of the five NIMH recognized disciplines qualified to address the mental health needs of increasingly diverse and prevalent mental health issues among American society. MHC and MFC/T presumably encompass alternative views of causality, symptom behavior, and methods of intervention. These presumed epistemological distinctions have led to the development of different training and educational experiences for them. However, in each case, counselor educators strive to provide the best quality training (Anderson & Rigazio-Digilio, 1995; Fong, 1998).

It is a widely accepted belief that the manner in which a client's concerns are conceptualized has profound impact on the manner in which counselors/therapists address various aspects of the therapeutic process (Johnson & Brehms, 1991; Sluzi, 1981). However, professional consensus is lacking in regard to the distinctiveness of differences based on conceptualizations used. A related, key aspect of attending to the mental health needs of the community, and being accountable, is to provide quality education in the endorsed standards of knowledge and competencies in selected counseling specializations. It follows that it is important to understand how specialized training affects students' thinking. Therefore, the primary purpose of this study was to examine how conceptualization of clients' concerns varied among students currently enrolled in graduate-level MHC or MFC/T programs.

The following discussion focuses on how trainee/student variables are associated with conceptualization of client concerns. Implications and recommendations also are discussed.

Limitations of this Study

Although this study used accepted methodology, limitations exist that should be considered to interpret the results appropriately. Considerations limiting the methodology of this study were presented in Chapter 3. Some of them are readdressed here briefly because the data may have been shaped by the collection procedures (Meichenbaum & Cameron, 1981).

Not all eligible trainees were notified of the opportunity to participate in this study. Notification was dependent upon membership in one of the identified listservs to which this study was posted and/or acquaintance with a graduate student who was aware of the study and who voluntarily passed on the information. This study followed the suggestions of Kittleson (1997) and Good (1997) to yield the highest response rate. Specifically, this study's initial posting occurred on Monday, September 23, 2002 to six listservs previously identified as being related to or developed for this study's population. Three reminder messages were posted, at approximately one-week intervals. The reminder messages served to address problems of e-mail purging and forgotten and/or misplaced messages. Nonetheless, participants may not have been representative of all students currently enrolled in master's- or doctoral-level programs with a specialization in either MHC or MFC/T.

Some eligible participants may not have had access to a computer and/or the Internet. However, given that institutes of higher learning now commonly require

students to be computer literate and to have access to the Internet, this limitation unlikely was of much significance.

Issues attributable to variations in computer hardware and operating systems software were not evident from the data obtained. However, software compatibility among various e-mail programs may not have presented recipients with consistent direct, point-and-click access to the study's web site. To limit the impact of this issue, potential recipients were provided instructions about "cutting and pasting" the study's web address (URL) into a server to gain access. As a result, this issue should not have affected participation in this study to any great extent.

Case vignette research validity is limited by the extent to which respondents can envision themselves in the situations portrayed. It is not possible to know fully the extent to which participants identified with the 18 possible response choices. Some may even have preferred response choices not represented. However, given the purpose of this study and the attention given to instrument development, these issues were likely of little significance.

Demographic representation in this study was widely dispersed. For example, 169 respondents were in CACREP-accredited programs, 18 in CACREP- and APA-accredited programs, 14 in CACREP- and COAMFTE-accredited programs, and one in either a COAMFTE- or an APA-accredited program. Similarly wide-ranging representation existed for gender, program enrollment type, preferred professional association, primary type of clinical experience, practica/internships completed, and reported professional affiliation of the respondent's primary supervisor/advisor/instructor. This situation demanded the use of conservative statistical analyses and limited the extent to which

interaction effects could be analyzed. Such variations must be considered when interpreting the results.

All research places demands on subjects (Gall, Borg, & Gall, 1996). In this study, students in the counseling programs of interest were targeted for participation, and some may have declined to participate because of time constraints or other reasons. The participants who did engage in this study voluntarily may therefore be somehow different than those who did not volunteer (Rosenthal & Rosnow, 1975).

Another consideration for this study was the volunteer's awareness of being a study participant. The e-mail solicitation for respondents and online consent form explained to the respondents that their responses were being examined for preferences in conceptualization of client concerns. Awareness of response analysis could have shaped the manner in which students selected their preferences. However, responses were constructed to reduce substantially attempts to surmise a "correct" way to respond in accordance with a particular specialization.

Incomplete submissions are inherent to computer-based (as well as other types of) surveys. This issue had an effect. Some participants chose not to answer a particular demographic question or vignette response; the demographic section in fact yielded the highest frequency of incomplete data. However, no participant responses were eliminated entirely from the database because of incomplete responding. Instead, response ratings were excluded from data analyses on a response-by-response basis, and only when they precluded a particular analysis.

Implications

This discussion seeks to clarify how respondents' conceptualizations of client concerns were associated with age, gender, academic major, academic program level, amount of practica/internships, primary type of practica/intership experiences, primary professional affiliation (if any), and their primary supervisor's/educator's/instructor's professional affiliation. Some of the ways that this study's methodology and findings can be linked to education and training, counseling practice, and research also are presented.

It is important to note that little research attention has been directed toward the investigation of trainees enrolled in academically-based counseling programs, and specifically those in MHC or MFC/T programs, and the relationships among trainee demographic variables and conceptualization of client concerns. Therefore, comparisons to previous research findings are limited.

Age

Age was included in this study to examine whether "life experience" was associated with response preferences in a predictable way. No clear pattern emerged between age and response preference for either MHC or MFC/T conceptual dimensions. Skovholt and Ronnestad (1992) found that the older a beginning graduate student was, the more quickly the student moved beyond imitation of experienced professionals to exploring conceptualizations congruent with their personal sense of being. However, a similar pattern was not found in this study. It appears that how age relates to conceptualization choice is not yet fully understood.

Gender

No gender-based differences in response choices were found. This finding supports Simmons's and Doherty's (1998) results. Specifically, gender had no substantial relationship to treatment planning and conceptualization. However, their research was conducted with clinical members of AAMFT from different training backgrounds rather than with trainees/students.

Academic Major

While this study failed to reject the hypothesis that no difference in trainees' conceptualization ratings are based on academic major (i.e., professional specialization), an interesting response pattern emerged when the seven of 18 statistically significant response differences were analyzed with respect to conceptual principles commonly associated with a particular academic specialization. Essentially, the emerging pattern illustrated a consistency between a trainee's identified academic major and program level (i.e., masters or doctorate) and those conceptual dimensions identified with a particular specialization. However, this pattern emerged only for some of the MHC and MFC/T conceptual response choices. For example, Vignette One, Response Two was designed to be a content focus conceptualization response type. Such a response is conceptually associated with MHC. Doctoral-level MHC's reported a statistically significantly higher mean response than did their counterparts in MFC/T. Masters-level MFC/T and MHC respondents also reported a statistically significantly higher mean than did doctoral-level MFC/Ts. These findings are theoretically consistent with conceptual dimensions associated with the respective counseling specializations. Nonetheless, this study could not substantiate a generalized conclusion about the relationship between academic major

and conceptualization ratings. Furthermore, previous research does not provide information about the influence of academic training in relationship to trainees' conceptualization and treatment planning.

In regard to interaction effects, this study's data set allowed for the analysis of interaction effects between academic major and age category, and between academic major and gender. No significant interaction effect was found between gender and academic major. For age category and academic major, the findings were significantly different in eight out of the 18 possible response choices. However, there was not a clear pattern between these interactions and conceptual responses associated with particular specializations.

Academic Program Level

Academic program level-based differences were found. Masters-level students reported higher preferences for MHC conceptual type responses and doctoral-level students had a stronger preference for MFC/T conceptualizations. Given that trainees entering a counseling program typically have been exposed to many educational and cultural norms that reinforce an individual orientation (i.e., MHC) for understanding a client's concerns (Huber & Carlson, 1994; Sexton, 1994; Worden, 1994), it is likely that a trainee's conceptualization tendencies are influenced by level of education. Further, this study's findings may reflect the philosophical stance and standardized training approach of those programs accredited by CACREP, which demands comprehensive training prior to and/or simultaneous with specialized training in marriage and family counseling (Stevens-Smith, Hinkle, & Stahmann, 1993). Specifically, 83.25% of the respondents for this study were currently enrolled in CACREP-accredited programs while specializing in

MHC or MFC/T at the master's or doctoral-level of training. Given this study's prevalence of trainees in CACREP-accredited programs, it was not unexpected that their educational level would influence students' response preferences.

In general, previous research findings are either primarily outside the focus of this study or conflict in regard to influence that level of education has on conceptualization. Some studies (e.g., Simmons & Doherty, 1998) found no relationship between the variables, while other studies (e.g., Skovholt & Ronnestad, 1992) found that trainees' conceptualization of client issues was strongly influenced by the nature of graduate education. While the association between academic program level and the conceptualization choice remains indistinct, these interpretations are supported by schema theory that calls attention to the integral connection between social factors, nature, and an understanding of conceptual development (Chinn, 1998).

Amount of Practica and/or Internships

In accordance with the majority decision rule, response mean differences for practica/internships trainees had completed were not found to be statistically significant. This finding supports the work of Dulaney and O'Connell (1963) who reported that it is essential for a person to have access, through learning (i.e., academic training), not experience, to a particular understanding of an issue before that understanding can be employed. Unfortunately, previous research on this attribute does not address directly the study of conceptualization qualities between specializations, but instead focuses primarily on the acquisition of experience and education as a prerequisite to the development of effective conceptualization and problem solving abilities (Kivilighan & Quigley, 1991; Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989).

Primary Setting for Practica and/or Internships

No previous research was found that directly studied this attribute among graduate students specializing in MHC or MFC/T. While this study found only one-third of the conceptual response means to be statistically significantly different based on the primary type of practica/interships experience of trainees, the findings presented an encouraging trend. In general, response preferences were conceptually consistent with dimensions associated with identified primary training experience.

Significant interaction effects between primary setting and amount of practica/internships were found in only 27.78% of the responses. At best, this finding suggests a weak association between the two variables. However, it is not unreasonable to suggest cautiously that this study's findings lend some support to previous research stating that conceptualization and treatment planning involve complex interactions between acquired knowledge and repeated experience (Gick, 1986; Tucker & Pinsoff, 1984; Perlesz, Stolk, & Firestone, 1990). Further, schema theory holds that conceptualization is shaped through interaction with a person's surroundings (e.g., primary practica/internships setting) and conceptual antecedents (e.g., amount of supervised practice).

Trainee's Professional Affiliation

Professional affiliation was included in this study to examine if a helping professional trainee's socialization through a particular professional affiliation is influential to treatment approach. That is, are the conceptual dimensions associated with a particular professional affiliation reflected in the manner in which trainees conceptualize their clients' concerns? Previous research findings (e.g., Brickman, Rabinowitz, Karuza,

Coates, Cohn, & Kidder, 1982; Falvey, 1992; Houts, 1984; Kopta, Newman, McGovern, & Sandrock, 1986; Plous & Zimbardo, 1986; Simmons & Doherty, 1998; Turner & Kofoed, 1984) acknowledged professional affiliation as an influential characteristic among practicing helping professionals. However, professional affiliation did not meet this study's established criteria to be considered influential to students' response choices. In this study, only four response choices were found to be statistically significantly different based on a student's identification with a particular professional affiliation and therefore support previous findings. Specifically, conceptualization varied in accordance with conceptual concepts commonly associated with particular professional affiliations. For example, students affiliated with AMHCA had a statistically significantly higher mean than students with either no affiliation or an IAMFC affiliation on the individual dynamic (MHC conceptual dimension) response of Vignette Three. A similar pattern was evidenced between a MHC conceptual dimension of Vignette One and two of the MFC/T conceptual dimensions of Vignette Three and identified professional affiliations.

Program Accreditation

Program accreditation was included in this study to examine whether philosophical differences in training, based on accreditation type, had an impact on response preferences. Only two of the 18 response choices revealed significant differences in means based on program accreditation. While the two statistically significant findings did demonstrate conceptual consistency between accrediting body and conceptual response type, two responses is a minimal pattern upon which to base suggestions of a pattern. No previous studies of this attribute were found.

Professional Affiliation of Trainees' Primary Supervisor/Educator/Instructor

Given that "theory and research is often mediated through [established professionals]," (Skovholt et al., 1992, p. 509), the reported professional affiliation of a trainee's primary supervisor/educator/instructor was included in this investigation. As for other variables in this study, this one did not meet this study's criteria to be considered influential to students' response choices. As such, this study cannot affirm previous findings about the influence of professional mentors. However, it is important to mention that of the four responses for which statistically significant differences were found, trainee conceptualization and treatment planning was consistent with conceptual dimensions commonly associated with the primary supervisor/educator/instructor identified by the student participant. The data derived from this study did not permit confirmation of other findings previously found to be significant to conceptualization. For example, it was not possible to test Beutler and McNabb's (1981) findings that the less experienced and the earlier in an education program a trainee was, the more likely the trainee was influenced by the preferred conceptualizations and professional affiliation of his/her primary supervisor/advisor/mentor.

Intercorrelations

Response patterns were examined within each academic subgroup and the findings varied. However, a trend toward conceptual dimension correlational consistency was evidenced in three of the four academic specializations. Conceptually consistent correlations were observed in 82.76% (CES-MFC/T), 89.29% (MFC/T-master's level), and 75.81% (MHC-master's level) of the responses found to be statistically significantly correlated. CES-MHC respondents did not have high percentages of theoretical

consistency. However, it is unclear to what extent the small number of participants identified in this group (N=6) impacted this finding. Nonetheless, these findings begin to suggest that education and training influence a trainee's conceptualization in a theoretically consistent manner.

Interpretations

Several factors associated with methodology are noteworthy, including considerations related to technology, request for participants, and the survey assessment tool.

Technological advances (e.g., the WWW and the Internet) have created new means to conduct research. The use of the WWW to conduct this study proved to have important advantages. For example, data collection was cost effective, simple, and eliminated transcription errors. Access to a geographically widespread population of research participants also was facilitated (Houston & Fiore, 1998). While these attributes certainly contribute to educators' recognition and use of the "information highway" as a research medium, this study also highlights some key challenges.

Multiple submissions and incomplete submissions are inherent concerns in computer-based surveys. Multiple submissions are those instances in which participants double click "send survey," which in turn results in data duplication. This occurrence can be substantially reduced and present no concern to reported data by utilizing a well-written gateway program that eliminates duplication. Similarly, researchers can conduct a careful visual inspection of the reported data. Finally, posting a reminder to only click once to submit responses substantially reduces the frequency of double submissions created by participants who have been "conditioned" to double click.

Regarding incomplete submissions, ethical considerations and the possibility of human error must be considered. First, it stands to reason that a person who decides to participate in a survey wants their data to have a bearing on the study. Second, it is not uncommon for many incomplete submissions to be the unintentional product of the computer medium (e.g., scrolling too quickly and/or forgetting to go back to a question the respondent wishes to consider further). Ethically, participants' rights (e.g., voluntary participation and right to discontinue participation at any time) must be protected. This problem can be reduced substantially by utilizing a computer program that returns respondents to the survey when not completed, indicates the points at which data are missing, and provides respondents with an option to discontinue participation. Of course, such a program could not be employed without participants being fully aware of the methodology. A carefully developed consent form that explains participant rights, methodological tools unique to the study, and other important information about the study can address these concerns adequately.

Another development related to WWW-based research involves variations in computer software programs, particularly e-mail programs that vary substantially across providers. Essentially, these variations can alter the content and capability of e-mail designed to notify participants of a study. For example, software variations may change the content by not accurately translating punctuation. At best, this can make an e-mail document difficult to read. Additionally, hyperlinks created in one context may not translate accurately to another context. While this is not a problem easily resolved, it can be substantially reduced. Careful selection of the software used to create an e-mail

document is helpful and precise directions by which eligible participants can manually access the survey should accompany hyperlinks.

An unexpected result emerged when each response type for each vignette was evaluated across all hypotheses posited by this study. Applying this study's majority decision rule to this context distinguishes two of the three possible MHC conceptually associated response types of Vignette One. In particular, V1's Content focus response had statistically significantly different means for 50% of the analyzed independent variables and interaction effects. V1's Individual dynamic response had statistically significantly different means in 66.67% of the analyzed independent variables and interaction effects. While no other responses met the majority rule, V3 results across hypotheses suggest a trend (e.g., 41.67% - Process focus and 41.67% - Circular causality) toward MFC/T conceptually associated responses having a higher percentage of statistically significant mean differences. It is unclear what caused these results. However, they suggest that something is occurring with how a vignette is presented and in what manner a particular vignette's associated conceptual dimension impacts response patterns. Interestingly, conceptual consistency between distinguished response conceptual styles and conceptual dimensions associated with the resource of a particular vignette existed in these observations.

Given the previous observation, consideration of the survey is important. While careful application of instrument development steps were employed to (reasonably) ensure that the data generated would provide answers to posited research questions and fit existing theory and research, further instrument evaluation is prudent. For example, additional experts could evaluate the instrument to establish further the content and

discriminant validity. Falvey and Hebert (1992) suggested that the instrument be evaluated by the targeted population (e.g., students/trainees in CACREP-approved MHC and MFC/T programs) for format (e.g., clarity of instructions and presented material), utility (e.g., usefulness in assessment purposes ranging from a tool for practitioner self-assessment to training experiences to credentialing and licensing purposes), and fidelity (e.g., extent to which case vignette is realistic and comprehensive).

By the same token, this instrument has potential as a teaching tool. When used for educational purposes, this instrument has the ability to provide students and educators with direct feedback about their conceptualization of client concerns (i.e., theoretical knowledge). The most valuable learning might occur when case vignettes are used in conjunction with other evaluative methods such as simulated and/or supervised practice (i.e., clinical knowledge and skill). Insight into the nature of personal conceptualizations is not limited to students however; practitioners might also benefit from use of this tool in continuing education. It also is reasonable to assume that this instrument could be adopted to evaluate conceptual tendencies not only among MHC and MFC/T students and practitioners, but also among other specializations. Lastly, it is possible that such information might clarify some of the questions consumers and managed care and other professionals have about how counselors approach client concerns.

During the request for participants phase (i.e., e-mail notification to identified listservs) of this study, another unexpected development emerged. Specifically, some participants on the *Counsgrads* listserv expressed "resentment" to the CACREP-approved population parameter of this study. *Counsgrads* has approximately 800 members and was developed to help graduate students across the country communicate.

"Resentment" was shared among listserv members in comments such as "… I might just live in a CACREP deprived state," "Nowadays, students are older and more entrenched in family and jobs and can't go away to one of the limited number of CACREP-approved programs," "I don't go to a CACREP accredited school either, but that doesn't mean it's not a good school or that my opinions don't have value," and "the university I attend has just started the CACREP process, but in [my state] the university I attend is known as having one of the best counseling programs. If I did not feel their program was good or adequate for what I want - I would not attend it!" Following expert consultation, this situation was handled via a listserv post that acknowledged expressed opinions, explained the methodological considerations, apologized for any unintended offense students experienced by the request, and welcomed MHC and MFC/T students to participate regardless of program accreditation. The latter was possible because the demographic section of this study addressed program accreditation type directly; students were informed of this.

Fortunately, this researcher's e-mail post seemed to resolve any confusion students' had expressed about this study's population. More importantly, however, this situation highlights students' desire to obtain a quality education and the increasingly important role program accreditation is having in the professionalization of counseling. Accreditation is a key step toward the legitimacy of a profession. The last decade has been characterized by continued growth in the number of accredited preparation programs or ones seeking accreditation. Graduating from an accredited program frequently eases a student's transition to a professional career in counseling. For example, some state boards require different criteria for professional licensure as a

counselor/therapist depending on whether a student graduated from an accredited-program. Classification as a Nationally Certified Counselor (NCC) also is frequently more easily managed when a student has graduated from an accredited program. While accreditation has many positive attributes, accreditation also creates challenges for aspiring programs, students, and faculty, including increased cost and time commitments. Meeting these challenges, and thereby advancing the unity of the counseling profession, seems to be dependent primarily upon the dedication of educators, particularly supervisors of clinical practice.

Recommendations

This study should be viewed as an initial step in examining the conceptualization characteristics of trainees in MHC and MFC/T training. Although the quantitative analysis of the data prompted the rejection of only one hypothesis, the data hints at what shapes trainees' conceptualizations and subsequent therapeutic interactions.

Assessment of students' conceptualizations is quite complex and establishing valid measurement criteria is essential. Additional methodological recommendations include providing a computer programming control that eliminates multiple submissions concerns and prompts participants to submit completed surveys. Accommodations to reduce the impact of computer software variances also should be provided.

In response to this study's findings and the limited existing research in this area, additional research is recommended. This study can be applied to pre-identified sets of participants that represent sufficient demographic variation to allow for additional relevant statistical analysis. Research that incorporates into the study design opportunities for students to introduce their own responses should be conducted. This less structured

format would increase the real life decision context and reduce cueing effects associated with rating-type response analysis. Conceptual change also should be studied at designated intervals across students' graduate education. Such investigation could produce a more identifiable analysis of the impact of various curricular/training experiences on conceptualization and treatment planning.

Additional research through an oral interview approach could produce clearer information on the problem solving strategies that influence students' analysis of vignettes and how these strategies subsequently impact their conceptualization preferences. Researchers also might consider profiling conceptualization/problem-solving approaches of clinical supervisors and comparing the results with students' conceptualization/problem solving approaches. Study of conceptualization/problem-solving strategies also might be extended to pre-counselor education candidates. Potentially, such information could provide a means of contributing to screening of candidates for program admission.

Future research might apply this study's design to distinct populations representing student preparation in accredited versus non-accredited programs to determine differences in conceptualization patterns used. Further, this study's design could be used in combination with an evaluative element that allows researchers to study the connection between how students conceptualize and what they actually do in practice.

The growth of a profession encompasses the way it processes information, conceptualizes, and plans clinical treatment (Barker, 1986). MHC and MFC/T counseling specializations present multiple, scientifically respectable theories and methods for bringing about desirable client change (Segal, 1991). Understanding how and what

impacts students' conceptualization of clients' concerns thus is essential to education and supervised practice (Huber & Carlson, 1994). Examination of this study's findings highlights the complex and often ambiguous connection between training factors and the manner in which students conceptualize clients' concerns (Gick, 1986). The extent that education and training can be identified, assessed, and evaluated for association with knowledge, skill, and practice acquisition affects the soundness upon which training of competent MHC and MFC/T professionals is based. As such, additional study to determine the effectiveness of various training pedagogies on conceptualization approaches within MHC and MFC/T is needed in order to advance the quality of preparation practices.

These suggestions do not represent an all-inclusive list. The salient point is that the manner in which client concerns are conceptualized profoundly impacts treatment and additional research is necessary to understand fully what factors contribute to this process; what are the key theoretical, clinical, and applied experiences to promote intended learning; and how various specializations can contribute uniquely to professional unity among counseling professionals. Admittedly, assessment of conceptualization is a formidable task that requires meticulous scrutiny and creativity. However, this study provides initial, valuable information to the as yet limited field of research in this area and upon which future research can be built.

Summary

This study suggests that there are both important similarities and differences in how students conceptualize client concerns based on various factors. Major findings of this research imply that level of education is associated with conceptual style. Although

this study did not support the rejection of other hypotheses, trends in the findings suggest that it is possible to clarify further the integral associations among social factors, nature, and conceptualization between MHC and MFC/T graduate students/trainees. This investigation also demonstrates a methodology for evaluating conceptualization. However, it remains unclear how response to written simulations corresponds with actual counseling behavior. Clearly, conceptualization is a complex task influenced by multiple factors in myriad ways. Nonetheless, consumers, students, educators, and the profession of counseling, among others stand to benefit from continued investigation into how MHC's and MFC/T's conceptualize client concerns.

APPENDIX A
REQUEST FOR PARTICIPANTS

SUBJECT: Survey Response Request
DATE: Monday, September 23, 2002; 09:00 EST

Dear Graduate Student:

Your perspective is requested!

If you are currently enrolled in a masters or doctoral-level, CACREP-approved mental health counseling or marriage and family counseling/therapy preparation program, I hope that you will take10-15 minutes to complete an online research study.

I am doctoral candidate at the University of Florida. I am also a nationally certified counselor and dually licensed in the state of Florida as a mental health counselor and a marriage and family therapist. I am currently conducting my dissertation research under the supervision of Dr. Larry C. Loesch.

The purpose of this study is to examine the relationship between academic training and conceptualization of client(s') concerns among masters and doctoral-level students currently enrolled in CACREP-approved mental health counseling or marriage and family counseling/therapy preparation programs. Data collection takes place via the Internet. A direct link to this research study is provided.

Participation is voluntary and your responses are anonymous within legal limits. Participation involves completing four tasks: Providing (a) informed consent and (b) demographic information, (c) responding to clinical vignettes by indicating your preference for particular client conceptualizations, and (d) requesting results of this study's findings, if desired. It will take only 10-15 minutes to complete the entire process.

Please click on the direct link provided and complete the survey before Friday, October 04, 2002. I appreciate your time. You are welcome to distribute this information to other students/trainees in your department, if you choose to do so. Participation and/or distribution of this information to your fellow students/trainees is voluntary; neither activity precludes the other.

http://alapt3.ed.uab.edu/kelly.htm

If you have any questions concerning the survey, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the

Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225 or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Thank you!

Sincerely,

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate –Department of Counselor Education, University Of Florida
kburch@ufl.edu

APPENDIX B
INFORMED CONSENT &
INSTRUCTIONS TO PARTICIPANTS

Thank you for taking the time to participate in a study about the influence of your training in mental health counseling or marriage and family counseling/therapy. This study is about how you conceptualize the therapeutic process. The information you provide will be helpful providing counselor educators with information about the manner in which training influences a counselor or therapist's thinking. Quality preparation benefits both clients and the counseling/therapy professions.

This study has two parts: a demographic information section and a survey. It will take only 10-15 minutes for you to complete both sections. Specifically, the demographic information section consists of 8 items. The survey consists of three case/client vignettes, each followed by six descriptions of ways to conceptualize the problem and the process of therapeutic intervention. A rating scale follows each conceptualization and you are asked to indicate how likely you are to think about and engage with the client/case within each conceptualization. You are allowed to make only one selection per response. Your responses will not be processed until you hit the "Submit" box; you may change your responses at any time prior to sending the survey.

Completing this survey is voluntary. You may withdraw your consent at any time without penalty. You do not have to answer any questions you do not wish to answer. Your responses are considered anonymous to the extent of the law. Please respond the way that fits you best. The only risk to you in participating is the slight possibility that you may experience discomfort if any of the vignettes and/or response choices reminds you of a particular counseling case in which you have been involved.

As my way of saying thank you, I will send the results of the study to you if you so request. The request page will appear after you have sent the survey. The request for

results is not connected to your responses in any way and will remain confidential. There are no other direct benefits to you for participating in this study. However, the information you provide has the potential to contribute to the quality of preparation that counselors/therapists receive. In turn, quality preparation impacts both clients and the counseling/therapy profession.

If you have any questions concerning the survey, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

By clicking on the "Go to Survey" link below, you are stating that you have read and understand the procedure described above and voluntarily agree to participate in this survey. Once you click on the link, you will automatically be taken to the survey.

Thanks for your help!

Go to Survey

APPENDIX C
STUDENT DEMOGRAPHIC INFORMATION

Please complete the following questions by marking the response that best describes you. For some questions, there may be more than one accurate response. These questions are marked with an asterisk (*) and ask you to click all that apply.

1. Age: Drop down category list, ranging from 20 to 50+ years

2. Gender:

   Female ☐ Male ☐

3. Please indicate the degree program in which you are **CURRENTLY** enrolled: (Select One)

   ☐ Masters-level Mental Health Counseling (MHC)

   ☐ Masters-level Marriage & Family Counseling (MFC/T)

   ☐ Counselor Education (CES) – Ph.D./Ed.D. with an emphasis in MHC

   ☐ CES – Ph.D./Ed.D. with an emphasis in MFC/T

4. Please indicate **ALL** accreditations applicable to the program in which you are currently enrolled: *(Select All that Apply)

   ☐ CACREP

   ☐ COAMFTE

   ☐ APA

5. Please indicate the clinical experience level in which you are **CURRENTLY** enrolled: (Select One)

   ☐ I have NOT yet enrolled in a supervised clinical experience (i.e., practicum or internship)

   ☐ Practicum 1 (up to 150 hours; 40 hours face-to-face contact)

   ☐ Practicum 2 (between 150-400 contact hours; 40-100 hours face-to-face)

   ☐ Internship in Counseling & Development (400-1000 contact hours; 100-350 face-to-face)

- [ ] I have completed ALL M.A./Ed.S. level clinical experiences
- [ ] Internship in Counseling & Development (advanced clinical experience post masters-level)
- [ ] Internship in Counselor Education (Doctoral-level)
- [ ] I have completed all masters and doctoral-level practice experiences

6. Please select the primary setting in which you have had clinical experience and/or are currently enrolled: (Select One)

- [ ] Mental Health Counseling
- [ ] Marriage and Family Counseling/Therapy

7. Select the primary professional organizational affiliation with which you are associated, if any: (Select One)

- [ ] American Mental Health Counselors Association (AMHCA)
- [ ] International Association of Marriage and Family Counselors (IAMFC)
- [ ] Association for Counselor Education and Supervision (ACES)
- [ ] I do NOT have a preferred professional association at this time

8. Please select the primary professional organizational affiliation of the person (e.g., supervisor, instructor, or advisor) who you consider most influential in your education and training: (Select One)

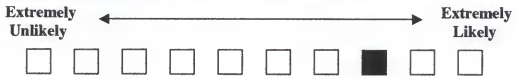
- [ ] AMHCA
- [ ] IAMFC
- [ ] ACES with a specialization in MHC
- [ ] ACES with a specialization in MFC/T
- [ ] None

APPENDIX D
VIGNETTES

Instructions: The survey consists of three case/client vignettes, each followed by six descriptions of ways to conceptualize the problem and the process of therapeutic intervention. A **rating scale** follows each conceptualization and you are asked to indicate how likely you are to think about and engage with the client/case within each conceptualization. Please check the box that best reflects your thinking; there are no correct or incorrect choices. You are allowed to make only one selection per response. Your responses will not be processed until you click the "Submit" box; you may change your responses at any time prior to sending the survey.

For example, let's assume that your favorite food is spaghetti, but you also are quite fond of seafood. Regarding the following statement, "My favorite place to dine out is a seafood restaurant,"

What is the likelihood that you would respond in this manner?



Vignette One

Leon is a 45-year-old postal employee who was evaluated at a clinic specializing in the treatment of depression. He claims to have felt constantly depressed since the first grade, without a period of "normal" mood for more than a few days at a time. His depression has been accompanied by lethargy, little or no interest or pleasure in anything, trouble concentrating, and feelings of inadequacy, pessimism, and resentfulness. His only periods of normal mood occur when he is home alone listening to music or watching TV.

On further questioning, Leon reveals that he cannot ever remember feeling comfortable socially. Even before kindergarten, if he was asked to speak in front of a group of his parents' friends, his mind would "go blank." He states that he felt overwhelming anxiety at children's social functions, such as birthday parties, which he either avoided or, if he went, attended in total silence. He could answer questions in class only if he wrote down the answers in advance; even then, he frequently mumbled and couldn't get the answer out. He met new children with his eyes lowered, fearing their scrutiny, expecting to feel humiliated and embarrassed. He was convinced that everyone around him thought he was "dumb" or "a jerk."

As he grew, Leon had a couple of neighborhood playmates, but he never had a "best friend." His school grades were good, but suffered when oral classroom participation was expected. As a teenager he was terrified of girls, and to this day has never gone on a date or even asked a girl for a date. This bothers him, although he is so often depressed that he feels he has little energy or interest in dating.

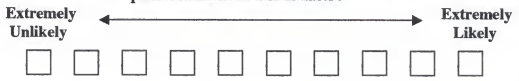
Leon attended college and did well for a while, then dropped out as his grades slipped. He remained very self-conscious and "terrified" of meeting strangers. He had trouble finding a job because he was unable to answer questions in interviews. He worked at a few jobs for which only a written test was required. He passed a Civil Service exam at age 24, and was offered a job in the post office on the evening shift. He enjoyed this job because it involved little contact with others. He was offered, but refused, several promotions because he feared the social pressures. Although by now he supervises a number of employees, he still finds it difficult to give instructions, even to people he has known for years. He has no close friends and avoids all invitations to socialize with co-workers. During the past several years, he has tried several therapies to help him get over his "shyness" and depression.

Leon has never experienced sudden anxiety or a panic attack in social situations or at other times. Rather, his anxiety gradually builds to a constant high level in anticipation of social situations. He has never experienced any psychotic symptoms.

Following are various responses that Leon's counselor/therapist might employ. As Leon's counselor/therapist:

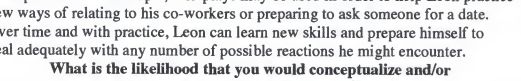
- I recognize that Leon's presenting problem serves some function or purpose in his family-of-origin as well as his relationships with persons outside his immediate family. I wonder what is the meaning of his behavior? One possible hypothesis is that Leon's behavior served to nurture and bind his family together. His behavior might be an outgrowth of his parents' inability to connect in an intimate and cohesive way. Or, his behavior might be a reflection of his desire not to "rock the boat" in a family that was filled with chaos and conflict. It is difficult to know what the function and meaning of his behavior are without further exploration of his family-of-origin, as well as his relationships with others. The therapeutic key lies in broadening the definition of his "problem" and thereby creating more alternatives for desired change.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



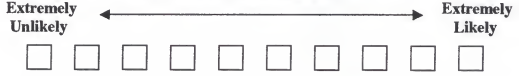
- Counseling/therapy will need to focus on the resolution of each specific problem Leon presents. For example, role-plays may be used in order to help Leon practice new ways of relating to his co-workers or preparing to ask someone for a date. Over time and with practice, Leon can learn new skills and prepare himself to deal adequately with any number of possible reactions he might encounter.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



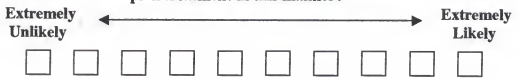
- I need to obtain a picture of Leon's psychological and life situations as complete as possible. It is also imperative to discern the depth of his depression, anxiety, and respective symptoms. Having addressed these concerns, it will be possible to discern exactly how Leon's thoughts/beliefs create particular distressful emotions, which in turn create particular life situations. While his problem resolution lies in restructuring his dysfunctional beliefs about himself and the world around him, effective counseling/therapy work will employ direct restructuring of his cognitions and developing new behavioral strategies. Both methods can help to resolve the cause of Leon's "shyness," depression, and social anxiety.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



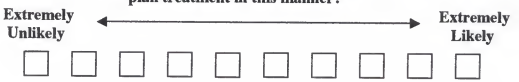
- Throughout counseling/therapy, the primary concern will be to understand and address how particular issues are portrayed in Leon's interactions with family, co-workers, and the larger social context. This does not preclude resolving and/or negotiating specific issues. However, the major focus will be on what is blocking the development of healthy relationships between Leon and others? What forces support the life of the problem?

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



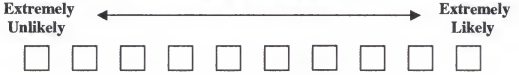
- I suspect that Leon's descriptions of his life and relationships are less than objective. I predict that the areas of inaccuracy will turn out to be clues to the core of his personality problems. His symptoms appear to be outward manifestations of unconscious conflicts that have their origins in his childhood experiences. Leon found it necessary to develop defensive reactions to these experiences. Leon's defenses seem to be maladaptive. It is important to understand thoroughly why Leon thinks, feels, and behaves the way he does. By answering "why," counseling/therapy allows Leon to understand the fundamental unconscious roots of his neurosis and subsequently break free from old, persisting maladaptive patterns.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



- Looking at the descriptions of Leon's interactions, it is clear that his difficulties are interrelated. That is, his "shyness" contributes to the ineffective way he relates to others, and this contributes to his depression and anxiety. While Leon may suffer from some biological tendency to be depressed, his descriptions suggest that there are underlying problems with the structure and rules established in his family-of-origin. Further exploration of Leon's relationships with his family will punctuate the repeating, self-perpetuating cycles of maladaptive interaction that have produced Leon's symptomology.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



Vignette Two

"You're lying!" yells 16-year-old Randy.

"No, I'm not, and don't talk to me in that tone!" strikes back his father, Mr. James.

A sneer forms on Randy's face, while Mr. James glares threateningly at his son.

Meanwhile, Mrs. James sits anxiously fearing an escalation. Randy's 11-year-old sister, Susan, nervously shifts in her chair. Next to Mrs. James sits 8-year-old Alice, sucking her thumb.

At this point the battle lines are drawn, the spectators are seated, and the moment freezes for what seems an interminable time. The room fills with raw hostility.

Sixteen-year-old Randy was referred by his school counselor for failing grades and unexcused absences. He was judged as "highly at risk" by school personnel. Both parents readily agreed to counseling because they had increasingly felt that Randy's behavior was beyond their control.

From all accounts, there were few problems in the family until Randy began high school. Mr. and Mrs. James felt that he then began to pull away from the family and continually test his parents' authority; arguments began over clothes, friends, curfew, and the like. Simplified, Randy would violate one of his parents' rules and his father would confront him. This confrontation led to an argument that quickly escalated into a screaming match. Mrs. James would enter the skirmish in an attempt to "calm them down before someone got hurt." More often than not, she would pull Randy away from his father and attempt to soothe her son. As for the two younger sisters, Susan would be in her room listening to every angry word, while Alice would seek her mother out in order to nurture and be nurtured. From Randy's perspective, all he wanted was "a little freedom" to make his own decisions.

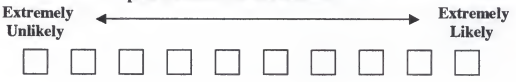
Mr. and Mrs. James presented their problem as their son's behavior. When asked to specify their problem more clearly, they expressed a desire to change Randy. Initially,

they brought up any number of problems with their son that they wanted changed, such as improved school performance, obeying their rules, a better attitude toward them, and so on.

Following are various responses that the James' counselor/therapist might employ. As the James' counselor/therapist:

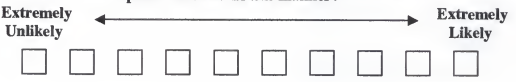
- Randy should be counseled individually, but the parents should be consulted on a periodic basis. Counseling/therapy would need to answer the question "What is wrong with Randy?" Perhaps Randy's behavior is an expression of his fear of dependency as he progresses toward adulthood. By having individual sessions with Randy, an environment of reduced tension would be created. This would allow him to proceed to address the underlying issues of his anger and develop new skills to handle his issue.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



- Several ideas come to mind regarding the basis of the James family's problem. For example, Randy's disobedience is the source of this family's problems. Or, Mrs. James lack of consistent support of her husband in his battles with his son lead to conflicting messages and subsequently Randy's "rebellious" behavior. Another possibility is Mr. James is too strict with Randy. As a result Randy is hostile and noncompliant with the rules established by his parents. Resolving this family's presenting problem is dependent upon discerning who or what is the culprit and empowering family members to change it.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



- Intervention with James' family to resolve their presenting issue would primarily involve facilitating family therapy sessions in which issues of respect, cooperation, and conflict resolution could be addressed. In so doing, an environment would be created in which possible solutions to Randy's behavioral problems could be negotiated. Topics of resolution would include Randy's curfew, his choice of friends, and his performance level in school.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?

Extremely Unlikely ← → **Extremely Likely**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- It is important to find out how each family member's behavior affects other family member's behavior, which in turn affects each individual family member. For example, Randy's "out of control" behavior and open hostility may be his reaction to his father's rules and restrictions. Given this pattern, Mrs. Smith appears to act as the peacemaker in the family. However, when she does neither son or husband feel supported and thereby become angrier with one another as well as with Mrs. Smith. Unfortunately, Randy's younger sisters are vicariously absorbing the tension and emotionally explosive exchanges. Thus, eleven-year-old Susan may be part of an interaction that supports his becoming "out of control" in the future. And, eight-year-old Alice may develop symptoms consistent with separation anxiety disorder. The focus of intervention would be to eliminate the view of Randy as the "bad guy," alter the Smith family's maladaptive pattern of interaction, and consequently resolve the concerns that prompted Randy's referral.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?

Extremely Unlikely ← → **Extremely Likely**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- Counseling/therapy needs to ascertain what the function, purpose and meaning is of Randy's behavior within the James' family. Several initial hypotheses might be: (1) Randy's "rebellious" behavior reflects the family's inability to transform a parent-child relationship into a parent-adolescent one; (2) Randy and his father are fighting over Mrs. James' attention; or (3) Randy fights with his father in an effort to defend what he perceives to be his father's oppression over his mother. Whether these hypotheses prove to be accurate or another function of Randy's behavior becomes apparent, counseling/therapy will focus upon understanding the interactional patterns, roles, rules, and boundaries of this family. Through such an understanding, the focus of treatment will be some aspect of restructuring or reorganizing this family and the way they interact.

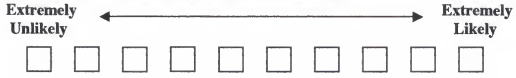
What is the likelihood that you would conceptualize and/or plan treatment in this manner?

Extremely Unlikely ← → **Extremely Likely**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- The primary therapeutic concern would be to understand Randy's behavior within the context of the family's functioning. It would need to be determined if Randy's behavior is maintaining the status quo in the family or forcing the family to change. Randy's behavior may be deflecting an unaddressed marital concern or some other undisclosed issue within the family. His behavior would thus serve to stabilize the family and remove any threat that the covert issue poses to the family. The focus of therapy thus would be on finding the dysfunctional patterns that underlie Randy's identified behavioral problems.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



Vignette Three

"I can get off it, but I can't stay off it." Quentin McCarthy was 43, and he was talking about alcohol. He liked to say that throughout his adult life he had been successful at two things – drinking and selling insurance. Now he was having trouble with both.

Quentin was the second of three sons born to parents who were both attorneys. Both of his brothers had been excellent students. Quentin was bright, but he had been hyperactive and the class clown. In school, he had never been able to focus his attention well enough to excel at anything but physical education.

To please his parents, after high school Quentin had tried a semester of junior college. It was worse than high school – the only thing that kept him going was guilt. Whereas his older brother was admitted to law school (with honors at entrance) and his younger brother mopped up the prizes at the state science fair, Quentin felt almost joyful when his birthday was that year's number four pick in the national draft lottery. The following day he enlisted in the Army.

Somewhere in his schooling Quentin had learned to type, so he was assigned to his battalion's administrative section. By comparison with some of the older men, his drinking was moderate. Although he had about the usual number of fights, he managed to avoid serious trouble. When he left the service at age 22, he had held onto his sergeant's stripes through two tours of duty in Vietnam.

After that, life suddenly became serious. Working part-time after hours in the Post Exchange, Quentin discovered that he was a natural salesman. So it seemed a logical move to take a job selling life insurance. It also seemed sensible to marry the boss's daughter. When his father-in-law died suddenly two years later, Quentin became sole proprietor of the agency.

"The business made me and it ruined me," he said. "I made a lot of money having lunch with people and selling them large policies. I told myself that I had to drink with them in order to make a sale, but I suppose that was just rationalization."

As time went on, Quentin's two-martini lunches turned into four-martini lunches. By the time he was 31, he was skipping lunch completely and nipping throughout the afternoon to "keep a glow on." At the end of the day, he was sometimes surprised to see how much had disappeared from the bottle he kept in his desk drawer.

The past year had brought Quentin two unpleasant surprises. The first came when his doctor informed him that the nagging pain just above his navel was an ulcer; for the sake of his health, he would have to stop drinking. The second, which in a way seemed worse because it injured his pride, occurred one afternoon over lunch. A long-time client of the agency apologetically said that he would be taking his substantial business elsewhere; his wife didn't feel comfortable that he was "doing business with a lush." Thinking back, Quentin realized that there had been several other, less blatant instances of customers departing the fold.

The result had been his resolve to quit, or at least reduce the amount of his drinking. ("Quitting is easy," he remarked ruefully. "I did it twice in one month.") At first he promised himself he would not drink before 5 p.m.; that proved impractical, and he later amended it to "around lunchtime." With the level in his desk drawer bottle receding as fast as ever, Quentin decided he would try Alcoholics Anonymous. "That was worse than useless," he explained. "The stories I heard from some of those people made me feel like a teetotaler."

A comment made by his wife, herself no stranger to alcohol, eventually brought him in for evaluation. "You used to drink to have a good time," she told him. "Now you drink because you need it."

By the time Quentin sought help, he was drinking the equivalent of nearly a pint of hard liquor per day. He declined a brief hospitalization to detoxify, and instead began an outpatient withdrawal regimen of decreasing doses of a benzodiazepine. He was asked to return in three days.

For three days, Quentin had drunk no alcohol. Beginning the second morning he had felt increasingly anxious. His anxiety grew throughout the day. Although he was exhausted at bedtime, he hardly slept at all. He looked gray and unhappy. His hand shook as he reached out an arm to have his blood pressure and pulse taken. Both of these measures were elevated. When asked, Quentin admitted that he had taken none of the medicine he had been given. "I wanted to do it myself," he explained.

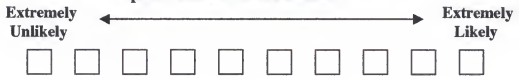
Over the next several days, Quentin's withdrawal symptoms abated. Within two weeks, he no longer needed the medication. However, because he felt strongly tempted to drink when he was having lunch with clients, he requested disulfiram (Antabuse) therapy.

Following are several responses that Quentin McCarthy's counselor/therapist might employ. As Quentin McCarthy's counselor/therapist:

- Quentin's symptomology is consistent with a diagnosis of Alcohol Dependence. His withdrawal symptoms only further underscore his primary diagnosis. Specifically, Quentin has developed *tolerance*, as exhibited by his afternoon drinking to keep his "glow on." He is drinking more than he intends, has

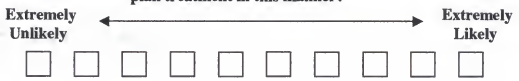
unsuccessfully attempted to control his drinking, and continues to drink despite the dangers to his health. In order to work effectively with Quentin to change his situation, counseling/therapy would focus on internal variables that impact his motivation to change. For example, what does Quentin view as the source of distress? How intense is his distress? What blocks his ability to deal effectively with his distress? At what stage of readiness is he for change? How does Quentin's sense of self/self-esteem impact his expectations for his capacity to benefit from treatment? Throughout our work, I would take an approach that supports Quentin's shifting needs regarding dependence versus independent decision-making.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



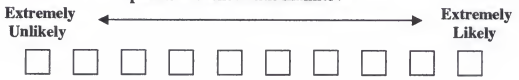
- Counseling with Quentin would involve understanding how his drinking fits into the family pattern of interaction, why his behavior has evolved at this particular point in time, how his family resolves its problems, how each significant family member shapes and reinforces the others' behaviors, and what function Quentin's drinking serves to the family system. Having discerned this information, counseling would focus primarily on adjusting the dysfunctional patterns of interaction that underlie Quentin's presenting alcohol dependence problem.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



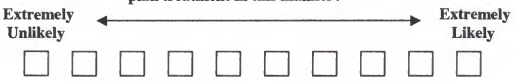
- It would be important to deal with Quentin's beliefs about why he drinks: what happened in his life to make him turn to alcohol? With further exploration of his beliefs and what caused his drinking, it will be possible to cognitively restructure his thoughts and develop new behavioral strategies to support his goal of alcohol use cessation.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



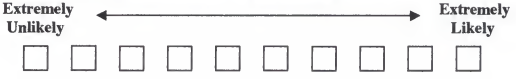
- Quentin appears to be the "scapegoat" for disruptions in his family. The cause of his alcohol dependence is purely arbitrary. Quentin's problem with drinking has emerged as a symptom of a dysfunctional pattern of interaction. From this therapeutic perspective, Quentin, along with other family members willing to participate in counseling, are able to develop awareness that behaviors are mutually and reciprocally shaped by each other. As such, appropriate reasonability can be determined and dysfunctional interactional patterns can be altered.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



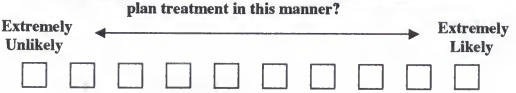
- It would be important to know what other goals are involved in Quentin's seeking counseling. In other words, it would be important to resolve specific, problematic cognitive, affective, behavioral issues. One implied goal is that Quentin needs to learn how to have business meetings without drinking. Therapy might involve role-play where Quentin is able to work out a specific plan of action to deal with specific situations he has faced in the past.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



- A comprehensive assessment is needed in order to gain better understanding of how (if at all) Quentin's family organizes itself around his drinking, if his drinking is connected to other marital or family problems, and if there are more serious issues that Quentin's drinking problem is masking. Based on a clearer understanding of the stated concern, along with family strengths and challenges, interventions would be designed to simultaneously address interactional dynamics supporting the problem and intrapsychic issues undermining Quentin's ability to quit drinking.

What is the likelihood that you would conceptualize and/or plan treatment in this manner?



This is the end of the survey. At this point, you may feel free to change any of your responses. When you are satisfied with your responses, please click the "Submit" button once.

Submit Reset

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APPENDIX E
REQUEST FOR RESULTS

Thank you for taking the time to participate in this study about the influence of your training in mental health counseling or marriage and family counseling/therapy. The information you provided is about how you conceptualize the therapeutic process and will be helpful by providing counselor educators with information about the manner in which training influences a counselor's or therapist's thinking.

As my way of saying thank you, I will send the results of the study to you if you so request. The request for results is not connected to your responses in any way and also will remain confidential. Please enter your e-mail address in the space provided below. Once you have entered your e-mail address, click the "Request for Results" button and your request will automatically be sent directly to me.

If you have any questions or comments concerning the survey, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Again, Thank You!

If you would like the results of this study, please enter your e-mail address below:

Email Address Field

Click "Submit" button once and your request will be on its way!

Submit Reset

APPENDIX F
PERMISSION TO REPRINT CORRESPONDENCE

Please note the corrected informatio below; we have updated the citation information to include the most recent edition of the Case Book, published in 2002. We've also corrected the name for the last author listed: First, MB. Thank you for your interest in our publications, Ann E

page numbers for the case are the same in the new edition noted.

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IF FEE IS SPECIFIED BELOW, SEND A COPY OF THIS LETTER/FORM ALONG WITH CHECK PAYABLE TO APPI ATTN EDITORIAL ASSISTANT, BOOKS.
PERMISSION IS CONTINGENT ON PAYMENT OF THE FEE.

8/8/02
DATE — FEE

Date: July 29, 2002

From: Kelly M. Burch-Ragan
5210 SW 86th Terrace
Gainesville, FL 32608
kburch@ufl.edu
(352) 335-6959

To: American Psychiatric Press, Inc.
1400 K Street, N.W.
Washington, DC 20005

Re: Request for Permission to Reprint

To Whom It May Concern:

This correspondence serves as my official request to reprint case material from one of your publications. The remainder of this letter specifies the material, the purpose, and by whom the material will be used.

My name is Kelly M. Burch-Ragan. I am a doctoral candidate at the University of Florida, in the Department of Counselor Education. My doctoral studies supervisory committee chairperson is Dr. Larry C. Loesch.

I am requesting permission to reprint a clinical vignette entitled, "The Jerk." The vignette is in R.L. Spitzer, M. Gibbon, A. Skodol, J.B. Willliams, and M.B. First's text ~~*DSM-IV Case Book*~~ ~~(4th ed.)~~ (pp. 124-125). The book was published in ~~1994~~ 2002. DSM-IV-TR

The clinical vignette will be used in my doctoral dissertation research, which investigates the likelihood with which students/trainees currently enrolled in masters and doctoral-level CACREP-approved Mental Health Counseling or Marriage and Family Counseling/Therapy preparation programs select different conceptualizations of client(s') concerns. The vignette will serve as a stimulus to evaluate student/trainee conceptualization and treatment planning characteristics. The vignette will not be evaluated in any manner.

Given the geographical location of participants, extent of researcher-participant interaction, monetary resources, and time necessary to complete my investigation, the World Wide Web will serve as the vehicle by which participants are able to access and respond to my investigation. The departmental chairpersons of appropriate programs will be notified of my study via e-mail. Chairpersons are asked to communicate the Web site location to appropriate participants. Participants will then voluntarily access the website to complete this study's instrument.

Complete acknowledgement of permission to reprint and the originating source of "the Jerk" case scenario will be posted in both my dissertation and on the Web site. Upon completion of data collection, the site will be permanently removed from the Web.

If you have any questions concerning my study or how the requested material will be utilized, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C.

Ann Eng
Permissions Manager, Books
American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, D.C. 20005

Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Thank you for your consideration and assistance.

Sincerely,

Kelly M. Burch-Ragan

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate, University of Florida, Department of Counselor Education

Date: July 29, 2002

From: Kelly M. Burch-Ragan
5210 SW 86th Terrace
Gainesville, FL 32608
kburch@ufl.edu
(352) 335-6959

To: **Brooks/Cole Publishing Company**
A Division of Wadsworth, Inc.
Pacific Grove, CA. 93950

Re: Request for Permission to Reprint

To Whom It May Concern:

This correspondence serves as my official request to reprint case material from one of your publications. The remainder of this letter specifies the material, the purpose, and by whom the material will be used.

My name is Kelly M. Burch-Ragan. I am a doctoral candidate at the University of Florida, in the Department of Counselor Education. My doctoral studies supervisory committee chairperson is Dr. Larry C. Loesch.

I am requesting permission to reprint a clinical vignette entitled, "the James family." The vignette is in M. Worden's text ***Family therapy basics*** (pp. 1-7). The book was published in 1994.

The clinical vignette will be used in my doctoral dissertation research, which investigates the likelihood with which students/trainees currently enrolled in masters and doctoral-level CACREP-approved Mental Health Counseling or Marriage and Family Counseling/Therapy preparation programs select different conceptualizations of client(s') concerns. The vignette will serve as a stimulus to evaluate student/trainee conceptualization and treatment planning characteristics. The vignette will not be evaluated in any manner.

Given the geographical location of participants, extent of researcher-participant interaction, monetary resources, and time necessary to complete my investigation, the World Wide Web will serve as the vehicle by which participants are able to access and respond to my investigation. The departmental chairpersons of appropriate programs will be notified of my study via e-mail. Chairpersons are asked to communicate the Web site location to appropriate participants. Participants will then voluntarily access the website to complete this study's instrument.

Complete acknowledgement of permission to reprint and the originating source of "the James family" case scenario will be posted in both my dissertation and on the Web site. Upon completion of data collection, the site will be permanently removed from the Web.

If you have any questions concerning my study or how the requested material will be utilized, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Thank you for your consideration and assistance.

Sincerely,

Kelly M Burch-Ragan M.A.Ed., LMFT, LMHC, NCC

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate, University of Florida, Department of Counselor Education

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Response # 65935

09/17/2002

Kelly Burch-Ragan
University of Florida
Department of Counselor Education
5210 SW 86th Terrace
Gainesville, FL 32608
Re: ISBN 0-534-23076-8

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Author(s): Worden ISBN: 0534230768
Publisher: Wadsworth © Year: 1994
Specific material: Vignette on pages 1, 4 & 7
Total pages: 3

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Author: Mark Worden
Publisher: Brooks/Cole Publishing
A work titled: Family Therapy Basics
Publication year: 2002 Edition Price: $10.00 Print run: 0

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Sincerely,
Pam Emery

Date: July 29, 2002

From: Kelly M. Burch-Ragan
5210 SW 86th Terrace
Gainesville, FL 32608
kburch@ufl.edu
(352) 335-6959

To: **The Guilford Press**
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72 Spring Street
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Re: Request for Permission to Reprint

To Whom It May Concern:

This correspondence serves as my official request to reprint case material from one of your publications. The remainder of this letter specifies the material, the purpose, and by whom the material will be used.

My name is Kelly M. Burch-Ragan. I am a doctoral candidate at the University of Florida, in the Department of Counselor Education. My doctoral studies supervisory committee chairperson is Dr. Larry C. Loesch.

I am requesting permission to reprint a clinical vignette entitled, "Quentin McCarthy." The vignette is in J. Morrison's text ***DSM-IV made easy: The clinician's guide to diagnosis*** (pp. 70-75). The book was published in 1995.

The clinical vignette will be used in my doctoral dissertation research, which investigates the likelihood with which students/trainees currently enrolled in masters and doctoral-level CACREP-approved Mental Health Counseling or Marriage and Family Counseling/Therapy preparation programs select different conceptualizations of client(s') concerns. The vignette will serve as a stimulus to evaluate student/trainee conceptualization and treatment planning characteristics. The vignette will not be evaluated in any manner.

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Complete acknowledgement of permission to reprint and the originating source of the "Quentin McCarthy" case scenario will be posted in both my dissertation and on the Web

site. Upon completion of data collection, the site will be permanently removed from the Web.

If you have any questions concerning my study or how the requested material will be utilized, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Thank you for your consideration and assistance.

Sincerely,

Kelly M Burch-Ragan, MAEd, LMFT, LMHC, NCC

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate, University of Florida, Department of Counselor Education

SUBJECT: Re: Permission to Reprint
DATE: Thursday, September 19, 2002, 1:58 p.m.

FROM: Kathy.Kuehl@guilford.com
TO: kel828@aol.com

Dear Kelly,

Thank you for your request. A one-time non-exclusive permission is granted at no charge to reprint the material requested below,

"Quentin McCarthy." The vignette is in J. Morrison's text DSM-IV made easy: The clinician's guide to diagnosis (pp. 70-75).

Please be sure to include a full credit line/citation for the material.

Sincerely,
Kathy Kuehl
Rights and Permissions

APPENDIX G
FIRST FOLLOW-UP E-MAIL REQUEST FOR PARTICIPANTS

SUBJECT: Important Survey Message
DATE: Sunday, September 29, 2002; 08:15 EST

Dear Counseling Graduate Student:

About one week ago you received an e-mail from me asking for your participation in an online dissertation research survey. The purpose of this study is to examine the relationship between academic training and conceptualization of client(s)' concerns among masters and doctoral-level students currently enrolled in CACREP-approved mental health counseling and marriage and family counseling/therapy preparation programs.

If you are currently enrolled in one of the eligible programs, I respectively request that you click on the direct link and complete this survey by Friday, October 04, 2002. Participation is voluntary and your responses are anonymous to the extent of the law. Participation involves completing four tasks: Providing (a) informed consent and (b) demographic information, (c) responding to clinical vignettes by indicating your preference for particular client conceptualizations, and (d) requesting results of this study's findings, if desired. It will take only 10-15 minutes to complete the entire process.

http://alapt3.ed.uab.edu/kelly.htm

I appreciate your time. You are welcome to distribute this information to other students/trainees in your department, if you choose to do so. Participation and/or distribution of this information to your fellow students/trainees is voluntary; neither activity precludes the other.

If you have any questions concerning the survey, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the

UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

Thank you!

Sincerely,

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate –Department of Counselor Education. University Of Florida
kburch@ufl.edu

APPENDIX H
SECOND FOLLOW-UP E-MAIL REQUEST FOR PARTICIPANTS

SUBJECT: Counseling Graduate Student's Important Message-Deadline Extended
DATE: Sunday, October 06. 2002, 09:20:00 EST

Dear Counseling Graduate Student:

Approximately two weeks ago you received an e-mail from me asking for your participation in an online dissertation research survey. I posted a reminder e-mail to this listserv approximately one week ago. **Many thanks** to those of you who have contributed your valuable time to the completion of this survey. **However, I need more completed surveys** in order to make meaningful conclusions about the findings.

I know that you are very busy and I will be most grateful to you if you will pause and give me just a few minutes of your time to complete this survey. It is critical for me to have your responses to complete my dissertation research.

So far I have received approximately 42% of the total number of completed surveys I need to make meaningful conclusions about the findings. **The deadline complete this survey has been extended to Friday, October 18, 2002.**

The purpose of this study is to examine the relationship between academic training and conceptualization of client(s)' concerns among masters and doctoral-level students enrolled in CACREP-approved mental health counseling and marriage and family counseling/therapy preparation programs. If you are currently enrolled in one of the eligible programs, **I respectively request that you complete this survey by Friday, October 18, 2002.**

There are two ways to access this survey. Click on the direct link provided at the end of this e-mail. If the direct link does not allow you to access the survey, please copy the survey's web address to your web address bar and click "Go." The survey's web address is

http://alapt3.ed.uab.edu/kelly.htm

Participation is voluntary and your responses are anonymous to the extent of the law. Participation involves completing four tasks: Providing (a) informed consent and (b) demographic information, (c) responding to clinical vignettes by indicating your preference for particular client conceptualization, and (d) requesting results of this study's findings, if desired. It will only take 10-15 minutes to complete the entire process.

I appreciate your time. **You are welcome to distribute this information to other students/trainees in your department, in fact I encourage you to do so and I will be especially appreciative for this effort** (i.e., posting on departmental listserv, forwarding this e-mail to other students, word of mouth, etc.). Participation and/or distribution of this information to your fellow students/trainees is voluntary; neither activity precludes the other.

If you have questions concerning this survey, please contact me by e-mail at kburch@ufl.edu or you may contact my supervisor, Dr. Larry C. Loesch at the Department of Counselor Education, University of Florida, P.O. Box 117046, 1215 Norman Hall, Gainesville, FL. 32611-7046; phone (352) 392-0731 ext. 225, or lloesch@coe.ufl.edu. Questions or concerns about participant rights can be directed to the UFIRB office, Box 112250, University of Florida, Gainesville, FL. 32611-2250; phone (352) 392-0433.

Thank you!

Sincerely,

Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Doctoral Candidate - Department of Counselor Education
University of Florida
kburch@ufl.edu

Note: Please click on the following link to expedite your way to this survey. Due to e-mail software compatibility, the direct link may not work on some systems. If this happens to you, please copy the web address to your web address browser bar and click "Go."
http://alapt3.ed.uab.edu/kelly.htm

APPENDIX I
INSTRUCTIONS TO COUNSELING PROFESSIONALS

The purpose of this instrument is to examine the likelihood with which students/trainees who are currently enrolled in masters and doctoral-level CACREP-approved mental health counseling or marriage and family counseling/therapy preparation programs select different conceptualizations of client(s') concerns. There are three vignettes and several conceptualization responses for each vignette. Each response is designed to reflect one of several possible conceptual dimensions.

- **Individual Dynamics** – The response focuses on the "identified client's" experiences, with particular attention being given to intrapersonal experiences (conscious and unconscious thought). The primary goal of this perspective is to bring about therapeutic change from within an individual.

- **Systemic Dynamics** – The response is guided by the principle that the whole is greater than the sum of its parts. As such, the nature of the problem (e.g., client symptomology) is viewed primarily as a reflection of and an attempt to resolve relational conflict. Intervention/treatment aims to facilitate change in a context larger than just the interpersonal (individual) context.

- **Linear Causality** – The response, like sequentially falling dominoes, suggests that event A causes event B and so on. Counseling focuses on the "cause" of the problem. The response also suggests that the client(s) possess some psychological trait that is causing the problem.

- **Circular Causality** – The response suggests that client(s') problems are part of an ongoing cycle of interaction which may be constructive or destructive to the healthy growth and development of a system and its respective members, both within a system (e.g., couple) and in relationship to larger systems (e.g., family-of-origin). Counseling focuses on changing the maladaptive patterns of interaction.

- **Content Focus** – The response focuses on the concrete issues addressed in a counseling session. In other words, the focus of therapy is on the "what" of the counseling/therapeutic discussion.

- **Process Focus** – The response focuses on "how" a particular counseling/therapeutic topic of discussion is portrayed by members of a client's system. Process is the systemic series of interactions that underlies the content discussion. Thereby, the same pattern of interaction will underlie different content issues.

- **Equilibrium Focus** - The response focuses on the dynamic balance between pathology and potential. The counseling intervention attempts to moderate and mediate the relationship between the two in a manner that is intended to achieve positive functioning.

Three vignettes of situations that students/trainees are likely to encounter in professional practice and selected conceptual responses for each of three vignettes follow. Please indicate the response type that you think each of the selected response reflects by **checking ONE TYPE for each response**.

APPENDIX J
VIGNETTES AS RATED BY COUNSELING PROFESSIONALS

Vignette One

Leon is a 45-year-old postal employee who was evaluated at a clinic specializing in the treatment of depression. He claims to have felt constantly depressed since the first grade, without a period of "normal" mood for more than a few days at a time. His depression has been accompanied by lethargy, little or no interest or pleasure in anything, trouble concentrating, and feelings of inadequacy, pessimism, and resentfulness. His only periods of normal mood occur when he is home alone listening to music or watching TV.

On further questioning, Leon reveals that he cannot ever remember feeling comfortable socially. Even before kindergarten, if he was asked to speak in front of a group of his parents' friends, his mind would "go blank." He states that he felt overwhelming anxiety at children's social functions, such as birthday parties, which he either avoided or, if he went, attended in total silence. He could answer questions in class only if he wrote down the answers in advance; even then, he frequently mumbled and couldn't get the answer out. He met new children with his eyes lowered, fearing their scrutiny, expecting to feel humiliated and embarrassed. He was convinced that everyone around him thought he was "dumb" or "a jerk."

As he grew, Leon had a couple of neighborhood playmates, but he never had a "best friend." His school grades were good, but suffered when oral classroom participation was expected. As a teenager he was terrified of girls, and to this day has never gone on a date or even asked a girl for a date. This bothers him, although he is so often depressed that he feels he has little energy or interest in dating.

Leon attended college and did well for a while, then dropped out as his grades slipped. He remained very self-conscious and "terrified" of meeting strangers. He had trouble finding a job because he was unable to answer questions in interviews. He worked at a few jobs for which only a written test was required. He passed a Civil Service exam at age 24, and was offered a job in the post office on the evening shift. He enjoyed this job because it involved little contact with others. He was offered, but refused, several promotions because he feared the social pressures. Although by now he supervises a number of employees, he still finds it difficult to give instructions, even to people he has known for years. He has no close friends and avoids all invitations to socialize with co-workers. During the past several years, he has tried several therapies to help him get over his "shyness" and depression.

Leon has never experienced sudden anxiety or a panic attack in social situations or at other times. Rather, his anxiety gradually builds to a constant high level in anticipation of social situations. He has never experienced any psychotic symptoms.

Following are various responses that Leon's therapist/counselor might employ. Please indicate the response type by checking ONE TYPE for each response.

- I recognize that Leon's presenting problem serves some function or purpose in his family-of-origin as well as his relationships with persons outside his immediate family. I wonder what is the meaning of his behavior? One possible hypothesis is that Leon's behavior served to nurture and bind his family together. His behavior might be an outgrowth of his parents' inability to connect in an intimate and cohesive way. Or, his behavior might be a reflection of his desire not to "rock the boat" in a family that was filled with chaos and conflict. It is difficult to know what the function and meaning of his behavior are without further exploration of

his family-of-origin, as well as his relationships with others. The therapeutic key lies in broadening the definition of his "problem" and thereby creating more alternatives for desired change.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- Counseling/therapy will need to focus on the resolution of each specific problem Leon presents. For example, role-plays may be used in order to help Leon practice new ways of relating to his co-workers or preparing to ask someone for a date. Over time and with practice, Leon can learn new skills and prepare himself to deal adequately with any number of possible reactions he might encounter.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- I need to obtain a picture of Leon's psychological and life situations as complete as possible. It is also imperative to discern the depth of his depression, anxiety, and respective symptoms. Having addressed these concerns, it will be possible to discern exactly how Leon's thoughts/beliefs create particular distressful emotions, which in turn create particular life situations. While his problem resolution lies in restructuring his dysfunctional beliefs about himself and the world around him, effective counseling/therapy work will employ direct restructuring of his cognitions and developing new behavioral strategies. Both methods can help to resolve the cause of Leon's "shyness," depression, and social anxiety.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- Throughout counseling/therapy, the primary concern will be to understand and address how particular issues are portrayed in Leon's interactions with family, co-workers, and the larger social context. This does not preclude resolving and/or negotiating specific issues. However, the major focus will be on what is blocking the development of healthy relationships between Leon and others? What forces support the life of the problem?

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
____	____	____	____

Content Focus	**Process Focus**	**Equilibrium Focus**
____	____	____

- I suspect that Leon's descriptions of his life and relationships are less than objective. I predict that the areas of inaccuracy will turn out to be clues to the core of his personality problems. His symptoms appear to be outward manifestations of unconscious conflicts that have their origins in his childhood experiences. Leon found it necessary to develop defensive reactions to these experiences. Leon's defenses seem to be maladaptive. It is important to understand thoroughly why Leon thinks, feels, and behaves the way he does. By answering "why," counseling/therapy allows Leon to understand the fundamental unconscious roots of his neurosis and subsequently break free from old, persisting maladaptive patterns.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
____	____	____	____

Content Focus	**Process Focus**	**Equilibrium Focus**
____	____	____

- Looking at the descriptions of Leon's interactions, it is clear that his difficulties are interrelated. That is, his "shyness" contributes to the ineffective way he relates to others, and this contributes to his depression and anxiety. While Leon may suffer from some biological tendency to be depressed, his descriptions suggest that there are underlying problems with the structure and rules established in his family-of-origin. Further exploration of Leon's relationships with his family will

punctuate the repeating, self-perpetuating cycles of maladaptive interaction that have produced Leon's symptomology.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

Vignette Two

"You're lying!" yells 16-year-old Randy.

"No, I'm not, and don't talk to me in that tone!" strikes back his father, Mr. James.

A sneer forms on Randy's face, while Mr. James glares threateningly at his son.

Meanwhile, Mrs. James sits anxiously fearing an escalation. Randy's 11-year-old sister, Susan, nervously shifts in her chair. Next to Mrs. James sits 8-year-old Alice, sucking her thumb.

At this point the battle lines are drawn, the spectators are seated, and the moment freezes for what seems an interminable time. The room fills with raw hostility.

Sixteen-year-old Randy was referred by his school counselor for failing grades and unexcused absences. He was judged as "highly at risk" by school personnel. Both parents readily agreed to counseling because they had increasingly felt that Randy's behavior was beyond their control.

From all accounts, there were few problems in the family until Randy began high school. Mr. and Mrs. James felt that he then began to pull away from the family and continually test his parents' authority; arguments began over clothes, friends, curfew, and the like. Simplified, Randy would violate one of his parents' rules and his father would confront him. This confrontation led to an argument that quickly escalated into a screaming match. Mrs. James would enter the skirmish in an attempt to "calm them down before someone got hurt." More often than not, she would pull Randy away from his father and attempt to soothe her son. As for the two younger sisters, Susan would be in her room listening to every angry word, while Alice would seek her mother out in order to nurture and be nurtured. From Randy's perspective, all he wanted was "a little freedom" to make his own decisions.

Mr. and Mrs. James presented their problem as their son's behavior. When asked to specify their problem more clearly, they expressed a desire to change Randy. Initially, they brought up any number of problems with their son that they wanted changed, such as improved school performance, obeying their rules, a better attitude toward them, and so on.

Following are various responses that the James' therapist/counselor might employ. Please indicate the response type by checking ONE TYPE for each response.

- Randy should be counseled individually, but the parents should be consulted on a periodic basis. Counseling/therapy would need to answer the question "What is wrong with Randy?" Perhaps Randy's behavior is an expression of his fear of dependency as he progresses toward adulthood. By having individual sessions with Randy, an environment of reduced tension would be created. This would allow him to proceed to address the underlying issues of his anger and develop new skills to handle his issue.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
_____	_____	_____	_____
Content Focus	**Process Focus**	**Equilibrium Focus**	
_____	_____	_____	

- Several ideas come to mind regarding the basis of the James family's problem. For example, Randy's disobedience is the source of this family's problems. Or, Mrs. James lack of consistent support of her husband in his battles with his son lead to conflicting messages and subsequently Randy's "rebellious" behavior. Another possibility is Mr. James is too strict with Randy. As a result Randy is hostile and noncompliant with the rules established by his parents. Resolving Randy's problem is dependent upon discerning who or what is the culprit and empowering Randy to change accordingly.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
_____	_____	_____	_____
Content Focus	**Process Focus**	**Equilibrium Focus**	
_____	_____	_____	

- Intervention with James' family to resolve their presenting issue would primarily involve facilitating family therapy sessions in which issues of respect, cooperation, and conflict resolution could be addressed. In so doing, an environment would be created in which possible solutions to Randy's behavioral

problems could be negotiated. Topics of resolution would include Randy's curfew, his choice of friends, and his performance level in school.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- It is important to find out how each family member's behavior affects other family member's behavior, which in turn affects each individual family member. For example, Randy's "out of control" behavior and open hostility may be his reaction to his father's rules and restrictions. Given this pattern, Mrs. Smith appears to act as the peacemaker in the family. However, when she does neither son or husband feel supported and thereby become angrier with one another as well as with Mrs. Smith. Unfortunately, Randy's younger sisters are vicariously absorbing the tension and emotionally explosive exchanges. Thus, eleven-year-old Susan may be part of an interaction that supports his becoming "out of control" in the future. And, eight-year-old Alice may develop symptoms consistent with separation anxiety disorder. The focus of intervention would be to eliminate the view of Randy as the "bad guy," alter the Smith family's maladaptive pattern of interaction, and consequently resolve the concerns that prompted Randy's referral.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- Counseling/therapy needs to ascertain what the function, purpose and meaning is of Randy's behavior within the James' family. Several initial hypotheses might be: (1) Randy's "rebellious" behavior reflects the family's inability to transform a parent-child relationship into a parent-adolescent one; (2) Randy and his father are fighting over Mrs. James' attention; or (3) Randy fights with his father in an effort to defend what he perceives to his father's oppression over his mother. Whether these hypotheses prove to be accurate or another function of Randy's behavior becomes apparent, counseling/therapy will focuses upon understanding the interactional patterns, roles, rules, and boundaries of this family. Through

such an understanding, the focus of treatment will be some aspect of restructuring or reorganizing this family and the way they interact.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

- The primary therapeutic concern would be to understand Randy's behavior within the context of the family's functioning. It would need to be determined if Randy's behavior is maintaining the status quo in the family or forcing the family to change. Randy's behavior may be deflecting an unaddressed marital concern or some other undisclosed issue within the family. His behavior would thus serve to stabilize the family and remove any threat that the covert issue poses to the family. The focus of therapy thus would be on finding the dysfunctional patterns that underlie Randy's identified behavioral problems.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____

Content Focus	Process Focus	Equilibrium Focus
____	____	____

Vignette Three

"I can get off it, but I can't stay off it." Quentin McCarthy was 43, and he was talking about alcohol. He liked to say that throughout his adult life he had been successful at two things – drinking and selling insurance. Now he was having trouble with both.

Quentin was the second of three sons born to parents who were both attorneys. Both of his brothers had been excellent students. Quentin was bright, but he had been hyperactive and the class clown. In school, he had never been able to focus his attention well enough to excel at anything but physical education.

To please his parents, after high school Quentin had tried a semester of junior college. It was worse than high school – the only thing that kept him going was guilt. Whereas his older brother was admitted to law school (with honors at entrance) and his younger brother mopped up the prizes at the state science fair, Quentin felt almost joyful when his birthday was that year's number four pick in the national draft lottery. The following day he enlisted in the Army.

Somewhere in his schooling Quentin had learned to type, so he was assigned to his battalion's administrative section. By comparison with some of the older men, his drinking was moderate. Although he had about the usual number of fights, he managed to avoid serious trouble. When he left the service at age 22, he had held onto his sergeant's stripes through two tours of duty in Vietnam.

After that, life suddenly became serious. Working part-time after hours in the Post Exchange, Quentin discovered that he was a natural salesman. So it seemed a logical move to take a job selling life insurance. It also seemed sensible to marry the boss's daughter. When his father-in-law died suddenly two years later, Quentin became sole proprietor of the agency.

"The business made me and it ruined me," he said. "I made a lot of money having lunch with people and selling them large policies. I told myself that I had to drink with them in order to make a sale, but I suppose that was just rationalization."

As time went on, Quentin's two-martini lunches turned into four-martini lunches. By the time he was 31, he was skipping lunch completely and nipping throughout the afternoon to "keep a glow on." At the end of the day, he was sometimes surprised to see how much had disappeared from the bottle he kept in his desk drawer.

The past year had brought Quentin two unpleasant surprises. The first came when his doctor informed him that the nagging pain just above his navel was an ulcer; for the sake of his health, he would have to stop drinking. The second, which in a way seemed worse because it injured his pride, occurred one afternoon over lunch. A long-time client of the agency apologetically said that he would be taking his substantial business elsewhere; his wife didn't feel comfortable that he was "doing business with a lush." Thinking back, Quentin realized that there had been several other, less blatant instances of customers departing the fold.

The result had been his resolve to quit, or at least reduce the amount of his drinking. ("Quitting is easy," he remarked ruefully. "I did it twice in one month.") At first he promised himself he would not drink before 5 p.m.; that proved impractical, and he later amended it to "around lunchtime." With the level in his desk drawer bottle receding as fast as ever, Quentin decided he would try Alcoholics Anonymous. "That was worse than useless," he explained. "The stories I heard from some of those people made me feel like a teetotaler."

A comment made by his wife, herself no stranger to alcohol, eventually brought him in for evaluation. "You used to drink to have a good time," she told him. "Now you drink because you need it."

By the time Quentin sought help, he was drinking the equivalent of nearly a pint of hard liquor per day. He declined a brief hospitalization to detoxify, and instead began an outpatient withdrawal regimen of decreasing doses of a benzodiazepine. He was asked to return in three days.

For three days, Quentin had drunk no alcohol. Beginning the second morning he had felt increasingly anxious. His anxiety grew throughout the day. Although he was exhausted at bedtime, he hardly slept at all. He looked gray and unhappy. His hand shook as he reached out an arm to have his blood pressure and pulse taken. Both of these measures were elevated. When asked, Quentin admitted that he had taken none of the medicine he had been given. "I wanted to do it myself," he explained.

Over the next several days, Quentin's withdrawal symptoms abated. Within two weeks, he no longer needed the medication. However, because he felt strongly tempted to drink when he was having lunch with clients, he requested disulfiram (Antabuse) therapy.

Following are several responses that Quentin McCarthy's therapist/counselor might employ. Please indicate the response type by checking ONE TYPE of response.

- Quentin's symptomology is consistent with a diagnosis of Alcohol Dependence. His withdrawal symptoms only further underscore his primary diagnosis. Specifically, Quentin has developed *tolerance*, as exhibited by his afternoon drinking to keep his "glow on." He is drinking more than he intends, has unsuccessfully attempted to control his drinking, and continues to drink despite the dangers to his health. In order to work effectively with Quentin to change his situation, counseling/therapy would focus on internal variables that impact his motivation to change. For example, what does Quentin view as the source of distress? How intense is his distress? What blocks his ability to deal effectively with his distress? At what stage of readiness is he for change? How does Quentin's sense of self/self-esteem impact his expectations for his capacity to benefit from treatment? Throughout our work, I would take an approach that supports Quentin's shifting needs regarding dependence versus independent decision-making.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
____	____	____	____
Content Focus		**Process Focus**	**Equilibrium Focus**
____		____	____

- Counseling with Quentin would involve understanding how his drinking fits into the family pattern of interaction, why his behavior has evolved at this particular point in time, how his family resolves its problems, how each significant family member shapes and reinforces the others' behaviors, and what function Quentin's drinking serves to the family system. Having discerned this information, counseling would focus primarily on adjusting the dysfunctional patterns of interaction that underlie Quentin's presenting alcohol dependence problem.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
____	____	____	____
Content Focus		**Process Focus**	**Equilibrium Focus**
____		____	____

- It would be important to deal with Quentin's beliefs about why he drinks: what happened in his life to make him turn to alcohol? With further exploration of his beliefs and what caused his drinking, it will be possible to cognitively restructure his thoughts and develop new behavioral strategies to support his goal of alcohol use cessation.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____
Content Focus		Process Focus	Equilibrium Focus
____		____	____

- Quentin appears to be the "scapegoat" for disruptions in his family. The cause of his alcohol dependence is purely arbitrary. Quentin's problem with drinking has emerged as a symptom of a dysfunctional pattern of interaction. From this therapeutic perspective, Quentin, along with other family members willing to participate in counseling, are able to develop awareness that behaviors are mutually and reciprocally shaped by each other. As such, appropriate reasonability can be determined and dysfunctional interactional patterns can be altered.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____
Content Focus		Process Focus	Equilibrium Focus
____		____	____

- It would be important to know what other goals are involved in Quentin's seeking counseling. In other words, it would be important to resolve specific, problematic cognitive, affective, behavioral issues. One implied goal is that Quentin needs to learn how to have business meetings without drinking. Therapy might involve role-play where Quentin is able to work out a specific plan of action to deal with specific situations he has faced in the past.

Individual Dynamics	Systemic Dynamics	Linear Causality	Circular Causality
____	____	____	____
Content Focus		Process Focus	Equilibrium Focus
____		____	____

- A comprehensive assessment is needed in order to gain better understanding of how (if at all) Quentin's family organizes itself around his drinking, if his drinking is connected to other marital or family problems, and if there are more serious issues that Quentin's drinking problem is masking. Based on a clearer understanding of the stated concern, along with family strengths and challenges, interventions would be designed to simultaneously address interactional dynamics supporting the problem and intrapsychic issues undermining Quentin's ability to quit drinking.

Individual Dynamics	**Systemic Dynamics**	**Linear Causality**	**Circular Causality**
_____	_____	_____	_____

Content Focus	**Process Focus**	**Equilibrium Focus**
_____	_____	_____

APPENDIX K
VALIDATION OF INSTRUMENT BY EXPERTS

This appendix summarizes expert panelist's response choices and comments regarding the instrument. The researcher's intended response choice ("keyed") and the expert panelists' response choices ("coded") are presented in table form. Panelists' comments follow the table.

KEYED	CODED Expert	CODED Expert	CODED Expert	CODED Expert	CODED Expert	% AGREEMENT
Vignette 1:						
Systemic	X	X	X	X	X	100%
Content	X	X	X	Equilibrium	X	80%
Linear	X	X	X	X	X	100%
Process	X	Equilibrium	X	X	X	80%
Individual	X	X	X	X	X	100%
Circular	X	X	X	X	Process	80%
Vignette 2:						
Individual	Equilibrium	X	X	X	X	80%
Linear	X	X	X	X	X	100%
Content	X	X	Systemic	X	X	80%
Circular	X	X	X	X	Systemic	80%
Systemic	X	X	X	X	Circular	80%
Process	X	X	Equilibrium	X	X	80%
Vignette 3:						
Individual	X	X	X	Content	X	80%
Process	Systemic	X	X	X	X	80%
Linear	X	X	X	X	X	100%
Circular	X	X	X	X	Systemic	80%
Content	X	X	X	Equilibrium	X	80%
Systemic	X	X	Equilibrium	X	X	80%

X = Expert's coded answer is equivalent to researcher's keyed answer.

COMMENTS:

- I've never seen an instrument like this one. It's a unique tool for exploring "perspectives" on certain client situations. Much more challenging than I originally thought it would be. One impediment going into this project was not

having a clear idea of what "equilibrium focus" might be. Through the process of elimination I found it to mean "two views in one." Of course, the researcher could not confirm or deny the meaning I had assigned to equilibrium focus until after the project was completed.

- These were pretty tough.

- Doing this instrument reminded me of something I had looked at some time ago regarding development of counselor responses to counseling situations. My belief was (and still is) that students in a counselor education program give responses at the lower to middle level of the Bloom's Taxonomy Scale and that experience and clinical supervision pushes those levels up somewhat. I always used the Bloom's scale in clinical supervision and could actually chart the transition of counselors along the professional road. I tied this into Norman's model of accretion (cognitive development) for understanding the novice-to-expert continuum.

- Circular and systemic were the most difficult to discern.

- I struggled with this because I tend to define systemic, process and circular differently so I had to keep coming back to the definitions given rather than my understanding of these concepts. For example, narrative theory recently includes more circularity and process (meaning-making) than the definition of systemic given here.

APPENDIX L
UNIVERSITY OF FLORIDA
INSTITUTIONAL REVIEW BOARD APPLICATION

INITIAL UFIRB APPLICATION

1. TITLE OF PROTOCOL:
Case Conceptualizations by Mental Health Counselors and Marriage and Family Counselors

2. PRINCIPAL INVESTIGATOR(s):
Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Department of Counselor Education, University of Florida
5210 SW 86th Terrace
Gainesville, FL 32608
(home)352-335-6959 (cellular) 352-278-3488
kel828@aol.com
(fax) N/A

3. SUPERVISOR (IF PI IS STUDENT):
Larry C. Loesch, Ph.D., NCC
Department of Counselor Education, University of Florida
1215 Norman Hall
P.O. Box 117046
(office) 352-392-0731, ext. 225
lloesch@coe.ufl.edu
(fax) 352-846-2697

4. DATES OF PROPOSED PROTOCOL:
From September 2002 To August 2003

5. SOURCE OF FUNDING FOR THE PROTOCOL:
Unfunded (i.e., personal funding)

6. SCIENTIFIC PURPOSE OF THE INVESTIGATION:
The primary objective of this research is to determine if there are differences in the preferred case conceptualization and treatment planning strategies between counselor education students whose professional goal is to become a mental health counselor (MHC) or to become a marriage and family counselor/therapist (MFC/T). The secondary objective is to determine associations among counselor trainees' case conceptualization and treatment planning preferences and variables including their degree program level (i.e., masters or doctorate); gender; age; primary professional association, if any (i.e., AMHCA, IAMFC, and/or ACES); number of supervised practica or internships completed; and primary supervisor's/educator's (e.g., academic advisor's) major professional association affiliation.

7. DESCRIBE THE RESEARCH METHODOLOGY IN NON-TECHNICAL LANGUAGE.
There will be four basic tasks that volunteer counselor trainees will be asked to complete for full participation in the study: Provide (a) informed consent and (b) demographic

information as identified in the preceding section, (c) indicate likelihood to use each of the various potential conceptualizations for several (hypothetical) clinical practice scenarios, and (d) request results, if desired.

Three clinical practice case vignettes will be developed, with each based on scenarios commonly encountered by counseling practitioners and having been approved by a review committee for accuracy of representation. Following each of the vignettes will be a (unique) set of six possible conceptualizations for treatment planning for the respective case described. The conceptualization choices also will have been reviewed for clarity and accuracy of representation of a particular approach to case conceptualization. Participants will be asked to indicate the likelihood that they would follow a particular conceptualization choice through use of a response scale of extremely unlikely to extremely likely (weighted 1 to 10). Each respondent will be requested to make a total of eighteen likelihood ratings, one for each of the six response choices for each of the three scenarios.

8. POTENTIAL BENEFITS AND ANTICIPATED RISK.

There is no more than minimal risk to participants. Completing this survey is voluntary. Responses are considered confidential and will not be connected directly to participants. The only risk in participating is the slight possibility that participants may experience discomfort if any of the vignettes and/or response choices reminds them of a particular counseling case in which participants have been involved.

9. DESCRIBE HOW PARTICIPANT(S) WILL BE RECRUITED, THE NUMBER AND AGE OF THE PARTICIPANTS, AND PROPOSED COMPENSATION (if any):

In order to facilitate participation in the study, an informed consent form, a demographic information questionnaire, and the six scenarios and their respective response choices will be posted to a website. Initial requests for research collaboration and student participation will be made to counselor preparation program chairpersons in all counselor education (or similarly named) departments having MHC and/or MFC/T programs accredited by CACREP. The department chairpersons will be requested to use any readily available means (e.g., posting a request on a local student list serv and/or asking program faculty to make announcements in their classes) to solicit students' participation in the study. The research participants will be master's and doctorate-level students currently enrolled in a CACREP-approved program for MHCs and MFC/Ts. A minimum of 200 student/trainee respondents will be sought. All participants are over the age of eighteen years. Counselor education students interested in participating in the study will be directed to the website. The study's website will be constructed so that student participation will involve selecting responses by mouse click, with demographic and response choices immediately compiled into a database for future analyses. Participant anonymity is ensured via website survey software and encryption techniques. Program chairpersons and faculty and participating students will be offered an opportunity to receive (via e-mail attachment) a summary of the results of the study upon its completion.

10. DESCRIBE THE INFORMED CONSENT PROCESS. INCLUDE A COPY OF THE INFORMED CONSENT DOCUMENT (if applicable). Upon accessing this study's website, participants (students/trainees) will be informed of the study's purpose, survey methodology, risks of participation, and persons to whom they may direct questions. Following this information, students will be asked to electronically select the "Go to Survey" link, which indicates that the counselor trainee has read and understood the procedure described and voluntarily agrees to participate in this survey.

(See attached copies of survey materials)

_____
Principal Investigator's Signature

_____
Supervisor's Signature

I approve this protocol for submission to the UFIRB:

_____

Dept. Chair/Center Director (Date)

From: IRB irb2@ufl.edu
Subject: UFIRB #2002-624 (Case Conceptualization by Mental Health Counselors...)
Date: Fri, 02 Aug 2002 14:43:17 EST

Dear Kelly,

We have received your IRB protocol submission back from review. The reviewer is concerned about the recruiting method and feels that students may feel pressured to participate. Can you get the email list and recruit the participants yourself? If so, you will need to forward a recruiting script to our office. Also, we need to know the maximum number of participants you plan to recruit for the study.

The informed consent needs to be revised as follows:

- Describe the benefits for participating or to others. If there are none add, "There are no direct benefits to you for participating in this study."
- Add, "Your participation is completely voluntary. You do not have to answer any question you wish not to answer. You may withdraw your consent at anytime without penalty."
- Add the extent of confidentiality. The participants identity will be either anonymous or confidential to the extent provided by law, but not both.

Please refer to the UFIRB # indicated above on all correspondence.

If you have questions about this message, please contact the IRB office by email at the address below. We will be happy to assist you during regular office hours Monday through Friday from 8:00 a.m.- 4:30 p.m. Please leave your new protocols and/or revisions to pending protocols on the shelf outside of the IRB office if the door is closed.

For additional information, visit the UFIRB web site at http://rgp.ufl.edu/irb/irb02.

Denise Long
UFIRB - Grants Specialist
98A Psychology Building / Box 112250
University of Florida
Gainesville, FL 32611-2250

IRB2@ufl.edu
Phone: (352) 392-0433
Fax: (352) 392-9234

Revisions For UFIRB #2002-624

1. TITLE OF PROTOCOL:
Case Conceptualizations by Mental Health Counselors and Marriage and Family Counselors

2. PRINCIPAL INVESTIGATOR(s):
Kelly M. Burch-Ragan, M.A.Ed., LMFT, LMHC, NCC
Department of Counselor Education, University of Florida
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(fax) N/A

3. SUPERVISOR (IF PI IS STUDENT):
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information as identified in the preceding section, (c) indicate likelihood to use each of the various potential conceptualizations for several (hypothetical) clinical practice scenarios, and (d) request results, if desired.

Three clinical practice case vignettes will be developed, with each based on scenarios commonly encountered by counseling practitioners and having been approved by a review committee for accuracy of representation. Following each of the vignettes will be a (unique) set of six possible conceptualizations for treatment planning for the respective case described. The conceptualization choices also will have been reviewed for clarity and accuracy of representation of a particular approach to case conceptualization. Participants will be asked to indicate the likelihood that they would follow a particular conceptualization choice through use of a response scale of extremely unlikely to extremely likely (weighted 1 to 10). Each respondent will be requested to make a total of eighteen likelihood ratings, one for each of the six response choices for each of the three scenarios.

8. POTENTIAL BENEFITS AND ANTICIPATED RISK.

There are no more than minimal risks to participants. Completing this survey is voluntary. Responses are considered anonymous to the extent provided by law. The only direct benefit of participation is the opportunity for respondents to receive a copy of the results, if desired. Students not choosing this option will receive no direct benefits for participation. The only risk in participating is the slight possibility that participants may experience discomfort if any of the vignettes and/or response choices reminds them of a particular counseling case in which participants have been involved.

9. DESCRIBE HOW PARTICIPANT(S) WILL BE RECRUITED, THE NUMBER AND AGE OF THE PARTICIPANTS, AND PROPOSED COMPENSATION (if any):

In order to facilitate participation in the study, an informed consent form, a demographic information questionnaire, and the six scenarios and their respective response choices will be posted to a website. Requests for student participation will be made by posting to e-mail listservs specifically identified as being related to or developed for this study's population (Birnbaum, 2000). The listserv announcements will inform students of the purpose and method of this investigation. Students will be asked to click the direct link provided and complete the survey by a specified date. Students also will be informed that they voluntarily may distribute this information to other students in their department, if they choose to do so. Participation and/or distribution of this information to fellow students/trainees is voluntary; neither activity precludes the other.

The research participants will be masters and doctorate-level students currently enrolled in a CACREP-approved programs for MHCs and MFC/Ts. A range of 200 to 400 student/trainee respondents will be sought. All participants are over the age of eighteen years. Counselor education students interested in voluntarily participating in the study will be directed to the website upon clicking the direct link. The study's website will be constructed so that student participation will involve selecting responses by mouse click, with demographic and response choices immediately compiled into a database for future

analyses. Participant anonymity is ensured via website survey software and encryption techniques. Participating students will be offered an opportunity to receive (via e-mail attachment) a summary of the results of the study upon its completion.

10. DESCRIBE THE INFORMED CONSENT PROCESS. INCLUDE A COPY OF THE INFORMED CONSENT DOCUMENT (if applicable). Upon accessing this study's website, participants (students/trainees) will be informed of the study's purpose, survey methodology, risks of participation, and persons to whom they may direct questions. Specifically, they will be informed that participation is voluntary, consent may be withdrawn at any time without penalty, and responses are anonymous to the extent provided by law. Furthermore, students will be informed that they do not have to answer any questions they do not wish to answer. Following this information, students will be asked to electronically select the "Go to Survey" link, which indicates that the counselor trainee has read and understood the procedure described and voluntarily agrees to participate in this survey.

(See attached copies of survey materials)

_____

Principal Investigator's Signature

_____

Supervisor's Signature

I approve this protocol for submission to the UFIRB:

_____

Dept. Chair/Center Director Date

Institutional Review Board

98A Psychology Bldg.
PO Box 112250
Gainesville, FL 32611-2250
Phone: (352) 392-0433
Fax: (352) 392-9234
E-mail: irb2@ufl.edu
http://rgp.ufl.edu/irb/irb02

DATE: 12-Aug-2002

TO: Kelly Burch-Ragan
5210 SW 86th Terrace
Gainesville, FL 32608

FROM: C. Michael Levy, Chair
University of Florida
Institutional Review Board

SUBJECT: **Approval of Protocol #2002-U-624**

TITLE: Case Conceptualizations by Mental Health Counselors and Marriage and Family Counselors

SPONSOR None

I am pleased to advise you that the University of Florida Institutional Review Board has recommended approval of this protocol. Based on its review, the UFIRB determined that this research presents no more than minimal risk to participants.

If you wish to make any changes to this protocol, including the need to increase the number of participants authorized, you must disclose your plans before you implement them so that the Board can assess their impact on your protocol. In addition, you must report to the Board any unexpected complications that affect your participants.

If you have not completed this protocol by 6-Aug-2003, please telephone our office (392-0433), and we will discuss the renewal process with you.

It is important that you keep your Department Chair informed about the status of this research protocol.

CML:dl/jw

cc:

APPENDIX M
RESPONSE MEANS

Ho1: Response Means by Age Category

Vignette – Conceptual Dimension	20-29	30-39	40-49	50+
Vignette 1				
Systemic Dynamics	5.45	5.13	5.17	4.88
Content Focus	6.54	5.76	5.21	5.20
Linear Causality	6.58	6.83	6.85	6.48
Process Focus	6.41	5.98	7.00	6.52
Individual Dynamics	4.51	4.00	4.36	3.72
Circular Causality	6.47	6.76	6.64	6.64
Vignette 2				
Individual Dynamics	4.25	3.63	3.47	2.56
Linear Causality	5.15	4.39	4.21	4.20
Content Focus	7.28	6.65	6.51	7.40
Circular Causality	7.32	7.87	7.68	7.24
Systemic Dynamics	6.39	6.74	6.30	7.76
Process Focus	6.36	6.83	6.89	7.24
Vignette 3				
Individual Dynamics	6.77	6.70	6.68	6.44
Process Focus	6.01	5.89	4.91	5.28
Linear Causality	6.39	6.50	6.06	5.60
Circular Causality	4.80	5.26	4.66	4.12
Content Focus	6.39	6.19	6.17	5.76
Systemic Dynamics	6.71	6.96	6.72	7.12

Ho2: Response Means by Number of Practica and/or Internships

Vignette – Conceptual Dimension	1	2	3	4	5	6	7	8
Vignette 1								
Systemic Dynamics	5.72	4.64	4.47	4.88	5.23	5.50	8.00	5.23
Content Focus	6.21	6.23	6.59	6.56	5.33	3.00	5.25	4.08
Linear Causality	6.72	7.09	6.82	7.16	6.63	5.00	4.50	5.92
Process Focus	6.62	6.86	6.24	6.38	6.00	9.50	7.50	6.69
Individual Dynamics	4.51	5.14	3.47	5.16	4.03	2.00	2.75	2.15
Circular Causality	6.70	6.64	6.35	6.38	6.45	8.50	8.75	6.85
Vignette 2								
Individual Dynamics	4.11	3.41	3.35	4.81	4.02	4.00	2.50	1.85
Linear Causality	4.53	4.95	4.00	5.03	4.73	3.00	4.00	4.00
Content Focus	7.13	6.95	6.94	7.38	6.95	4.50	4.75	6.15
Circular Causality	7.43	7.55	7.94	7.53	7.53	9.50	8.25	7.00
Systemic Dynamics	6.17	6.59	6.41	6.75	6.32	6.50	8.25	7.62
Process Focus	6.57	6.81	7.00	6.78	6.41	8.50	7.25	7.62
Vignette 3								
Individual Dynamics	6.49	6.90	7.71	6.47	7.08	6.00	4.75	5.31
Process Focus	5.60	5.81	6.18	5.19	5.56	6.00	6.75	5.77
Linear Causality	6.32	6.29	5.94	6.69	6.47	5.00	3.25	5.23
Circular Causality	4.62	4.90	4.24	4.32	4.85	7.00	5.75	6.46
Content Focus	6.45	5.90	6.88	7.16	5.63	5.00	5.00	5.62
Systemic Dynamics	6.98	7.33	7.24	5.84	6.54	9.00	7.75	8.00

Ho3: Response Means for Gender

Vignette - Conceptual Dimension	Female (N)	Male (N)
Vignette 1		
Systemic Dynamics	5.23 (152)	5.22 (46)
Content Focus	5.72 (152)	6.35 (46)
Linear Causality	6.79 (150)	6.52 (44)
Process Focus	6.42 (149)	6.53 (45)
Individual Dynamic	4.11 (150)	4.51 (45)
Circular Causality	6.63 (153)	6.58 (45)
Vignette 2		
Individual Dynamic	3.66 (149)	3.67 (45)
Linear Causality	4.52 (149)	4.78 (45)
Content Focus	7.00 (150)	6.86 (44)
Circular Causality	7.65 (151)	7.27 (44)
Systemic Dynamic	6.56 (152)	6.22 (45)
Process Focus	6.78 (153)	6.58 (45)
Vignette 3		
Individual Dynamic	6.67 (149)	7.00 (45)
Process Focus	5.59 (148)	5.73 (45)
Linear Causality	6.30 (149)	6.16 (45)
Circular Causality	4.73 (145)	4.78 (45)
Content Focus	6.13 (149)	6.44 (45)
Systemic Dynamic	6.90 (148)	6.62 (45)

Ho4: Response Means for Academic Major (i.e., Professional Specialization)

Vignette – Conceptual Dimension	CES-MFC/T	CES-MHC	MFC/T	MHC
Vignette 1				
Systemic Dynamics	6.09	3.25	5.59	5.10
Content Focus	4.00	6.83	6.56	5.89
Linear Causality	5.42	7.40	6.69	6.87
Process Focus	6.81	7.20	6.28	6.42
Individual Dynamics	2.29	3.40	4.19	4.47
Circular Causality	7.56	7.83	6.72	6.58
Vignette 2				
Individual Dynamics	2.00	3.50	3.75	3.85
Linear Causality	3.94	4.50	4.88	4.60
Content Focus	5.76	7.20	7.06	7.09
Circular Causality	7.88	7.00	7.50	7.56
Systemic Dynamics	7.88	4.67	6.59	6.37
Process Focus	7.89	6.50	6.88	6.57
Vignette 3				
Individual Dynamics	6.06	7.83	6.41	6.86
Process Focus	6.44	5.80	6.63	5.30
Linear Causality	5.06	7.17	6.53	6.31
Circular Causality	6.31	4.60	5.47	4.39
Content Focus	5.19	8.00	6.63	6.15
Systemic Dynamics	8.05	5.60	7.47	6.58

Ho4a: Response Means for Age Category by Academic Major (i.e., Professional Specialization)

Vignette – Conceptual Dimension Age Category	CES-MFC/T (N)	CES-MHC (N)	MFC/T (N)	MHC (N)
Vignette 1				
Systemic Dynamics				
20 – 29	6.75 (4)	1.00 (1)	5.41 (17)	5.45 (55)
30 – 39	7.00 (7)	3.00 (1)	5.78 (9)	4.68 (37)
40 – 49	5.80 (5)	2.00 (1)	5.00 (4)	5.18 (38)
50 +	5.00 (3)	4.00 (3)	7.33 (3)	4.56 (16)
Content Focus				
20 – 29	4.25 (4)	6.00 (1)	6.88 (17)	6.61 (54)
30 – 39	4.00 (7)	8.00 (1)	5.56 (9)	6.08 (37)
40 – 49	4.20 (5)	2.00 (1)	6.50 (4)	5.29 (38)
50 +	2.67 (3)	8.33 (3)	7.67 (3)	4.63 (16)
Linear Causality				
20 – 29	4.25 (4)	6.00 (1)	6.41 (17)	6.81 (54)
30 – 39	5.86 (7)	8.00 (1)	6.89 (9)	6.97 (37)
40 – 49	5.60 (5)	8.00 (1)	6.00 (4)	7.08 (37)
50 +	3.67 (3)	7.67 (3)	8.00 (3)	6.50 (16)
Process Focus				
20 – 29	8.00 (4)	4.00 (1)	6.18 (17)	6.41 (54)
30 – 39	5.86 (7)	7.00 (1)	5.56 (9)	6.08 (37)
40 – 49	7.60 (5)	9.00 (1)	7.25 (4)	6.84 (37)
50 +	6.67 (3)	8.33 (3)	7.00 (3)	6.06 (16)
Individual Dynamics				
20 – 29	3.00 (4)	6.00 (1)	3.71 (17)	4.85 (54)
30 – 39	2.57 (7)	2.00 (1)	5.11 (9)	4.05 (37)
40 – 49	1.60 (5)	3.00 (1)	3.25 (4)	4.89 (37)
50 +	1.33 (3)	3.00 (3)	6.33 (3)	3.81 (16)
Circular Causality				
20 – 29	7.75 (4)	7.00 (1)	6.53 (17)	6.35 (54)
30 – 39	7.14 (7)	9.00 (1)	6.67 (9)	6.65 (37)
40 – 49	8.20 (5)	7.00 (1)	7.00 (4)	6.38 (37)
50 +	7.00 (3)	8.00 (3)	7.67 (3)	6.13 (16)

Ho4a – Continued

Vignette – Conceptual Dimension Age Category	CES-MFC/T (N)	CES-MHC (N)	MFC/T (N)	MHC (N)
Vignette 2				
Individual Dynamics				
20 – 29	2.50 (4)	8.00 (1)	3.82 (17)	4.45 (53)
30 – 39	2.57 (7)	2.00 (1)	4.22 (9)	3.73 (37)
40 – 49	1.20 (5)	7.00 (1)	3.50 (4)	3.81 (37)
50 +	1.33 (3)	1.33 (3)	3.67 (3)	2.81 (16)
Linear Causality				
20 – 29	5.25 (4)	3.00 (1)	5.06 (17)	5.21 (53)
30 – 39	2.29 (7)	5.00 (1)	4.22 (9)	4.81 (37)
40 – 49	3.60 (5)	4.00 (1)	5.75 (4)	4.14 (37)
50 +	5.00 (3)	5.00 (3)	5.33 (3)	3.69 (16)
Content Focus				
20 – 29	6.25 (4)	4.00 (1)	7.06 (17)	7.48 (54)
30 – 39	4.71 (7)	9.00 (1)	6.44 (9)	7.00 (37)
40 – 49	5.60 (5)	6.00 (1)	7.75 (4)	6.51 (37)
50 +	6.33 (3)	8.67 (3)	6.67 (3)	7.50 (16)
Circular Causality				
20 – 29	8.00 (4)	5.00 (1)	7.12 (17)	7.37 (54)
30 – 39	8.14 (7)	9.00 (1)	8.22 (9)	7.70 (37)
40 – 49	7.80 (5)	10.00 (1)	8.00 (4)	7.57 (37)
50 +	7.33 (3)	6.00 (3)	7.33 (3)	7.44 (16)
Systemic Dynamics				
20 – 29	8.50 (4)	1.00 (1)	6.00 (17)	6.46 (54)
30 – 39	8.00 (7)	1.00 (1)	7.44 (9)	6.49 (37)
40 – 49	8.40 (5)	3.00 (1)	6.25 (4)	6.11 (37)
50 +	6.00 (3)	7.67 (3)	7.67 (3)	6.56 (16)
Process Focus				
20 – 29	6.50 (4)	4.00 (1)	6.18 (17)	6.44 (54)
30 – 39	8.29 (7)	7.00 (1)	7.11 (9)	6.49 (37)
40 – 49	9.20 (5)	7.00 (1)	8.00 (4)	6.46 (37)
50 +	6.33 (3)	7.00 (3)	8.33 (3)	7.25 (16)

Ho4a – Continued

Vignette – Conceptual Dimension Age Category	CES-MFC/T (N)	CES-MHC (N)	MFC/T (N)	MHC (N)
Vignette 3				
Individual Dynamics				
20 – 29	6.50 (4)	10.00 (1)	6.06 (17)	6.96 (53)
30 – 39	3.86 (7)	7.00 (1)	7.56 (9)	7.03 (37)
40 – 49	6.00 (5)	8.00 (1)	5.75 (4)	6.84 (37)
50 +	7.00 (3)	7.33 (3)	6.33 (3)	6.19 (16)
Process Focus				
20 – 29	7.25 (4)	6.00 (1)	6.12 (17)	5.89 (53)
30 – 39	6.71 (7)	8.00 (1)	7.56 (9)	5.27 (37)
40 – 49	6.20 (5)	4.00 (1)	6.75 (4)	4.57 (37)
50 +	5.33 (3)	4.67 (3)	7.00 (3)	5.06 (16)
Linear Causality				
20 – 29	5.00 (4)	7.00 (1)	5.41 (17)	6.79 (53)
30 – 39	4.00 (7)	9.00 (1)	7.33 (9)	6.70 (37)
40 – 49	5.60 (5)	7.00 (1)	7.75 (4)	5.92 (37)
50 +	4.00 (3)	6.67 (3)	8.67 (3)	5.13 (16)
Circular Causality				
20 – 29	6.00 (4)	4.00 (1)	5.29 (17)	4.56 (52)
30 – 39	8.14 (7)	7.00 (1)	6.56 (9)	4.35 (37)
40 – 49	6.80 (5)	5.00 (1)	3.00 (4)	4.54 (37)
50 +	4.00 (3)	3.33 (3)	6.67 (3)	3.81 (16)
Content Focus				
20 – 29	5.25 (4)	8.00 (1)	6.65 (17)	6.36 (53)
30 – 39	5.00 (7)	8.00 (1)	5.67 (9)	6.49 (37)
40 – 49	5.20 (5)	8.00 (1)	6.75 (4)	6.19 (37)
50 +	5.00 (3)	8.00 (3)	8.33 (3)	5.00 (16)
Systemic Dynamics				
20 – 29	7.75 (4)	2.00 (1)	7.12 (17)	6.58 (53)
30 – 39	8.86 (7)	4.00 (1)	7.78 (9)	6.49 (37)
40 – 49	9.00 (5)	8.00 (1)	7.50 (4)	6.30 (37)
50 +	6.33 (3)	6.33 (3)	8.00 (3)	7.25 (16)

Ho4b: Response Means for Gender by Academic Major (i.e., Professional Specialization)

Vignette – Conceptual Dimension Gender	CES-MFC/T	CES-MHC	MFC/T	MHC
Vignette 1				
Systemic Dynamics				
Female	6.27	3.50	5.48	5.10
Male	5.66	3.00	6.00	5.10
Content Focus				
Female	3.45	6.00	6.56	5.74
Male	5.00	8.50	6.57	6.42
Linear Causality				
Female	5.18	7.00	6.72	6.95
Male	5.83	8.00	6.57	6.55
Process Focus				
Female	7.30	7.00	6.56	6.30
Male	6.00	7.50	5.29	6.87
Individual Dynamics				
Female	2.00	4.33	3.68	4.14
Male	2.83	2.00	6.00	4.67
Circular Causality				
Female	7.50	7.00	6.80	6.49
Male	7.67	9.50	6.43	6.20
Vignette 2				
Individual Dynamics				
Female	1.91	4.25	3.28	3.90
Male	2.17	2.00	5.43	3.67
Linear Causality				
Female	3.64	5.25	4.80	4.52
Male	4.50	3.00	5.14	4.87
Content Focus				
Female	5.45	6.00	7.24	7.13
Male	6.33	9.00	6.43	6.93

Ho4b – Continued

Vignette – Conceptual Dimension Gender	CES-MFC/T	CES-MHC	MFC/T	MHC
Circular Causality				
Female	8.18	5.75	7.80	7.63
Male	7.33	9.50	6.43	7.31
Systemic Dynamics				
Female	8.73	5.00	6.76	6.36
Male	6.33	4.00	6.00	6.40
Process Focus				
Female	7.92	6.25	7.00	6.63
Male	7.83	7.00	6.43	6.33
Vignette 3				
Individual Dynamics				
Female	5.90	8.00	6.52	6.73
Male	6.33	7.50	6.00	7.33
Process Focus				
Female	6.79	4.67	6.64	5.27
Male	6.00	7.50	6.57	5.37
Linear Causality				
Female	5.10	7.50	6.52	6.32
Male	5.00	6.50	6.57	6.27
Circular Causality				
Female	7.30	4.33	5.48	4.33
Male	4.67	5.00	5.43	4.63
Content Focus				
Female	5.10	7.50	6.56	6.08
Male	5.33	9.00	6.86	6.40
Systemic Dynamics				
Female	8.45	5.00	7.64	6.62
Male	7.33	6.50	6.86	6.43

Ho5: Response Means for Student Academic Program Level

Vignette - Conceptual Dimension	Masters-level	Doctoral-level
Vignette 1		
Systemic Dynamics	5.17	5.84
Content Focus	6.02	4.21
Linear Causality	6.82	5.53
Process Focus	6.37	7.16
Individual Dynamic	4.45	2.26
Circular Causality	6.52	7.42
Vignette 2		
Individual Dynamic	3.87	2.21
Linear Causality	4.68	3.89
Content Focus	7.08	5.68
Circular Causality	7.54	7.53
Systemic Dynamic	6.39	7.63
Process Focus	6.62	7.63
Vignette 3		
Individual Dynamic	6.84	5.26
Process Focus	5.59	6.00
Linear Causality	6.40	4.79
Circular Causality	4.64	6.37
Content Focus	6.29	5.42
Systemic Dynamic	6.70	8.05

Ho6: Response Means for Student's Primary Professional Affiliation

Vignette – Conceptual Dimension	ACES	AMHCA	IAMFC	None
Vignette 1				
Systemic Dynamics	4.86	5.27	5.96	5.19
Content Focus	5.46	5.84	6.00	5.98
Linear Causality	7.00	6.76	6.43	6.69
Process Focus	6.54	6.80	7.00	6.20
Individual Dynamics	3.14	5.03	4.09	4.35
Circular Causality	6.57	6.52	7.61	6.46
Vignette 2				
Individual Dynamics	3.81	3.65	2.86	3.78
Linear Causality	4.40	5.13	4.14	4.58
Content Focus	7.00	6.87	6.87	7.01
Circular Causality	7.69	7.66	7.83	7.44
Systemic Dynamics	6.56	6.03	7.57	6.36
Process Focus	6.57	6.61	7.61	6.64
Vignette 3				
Individual Dynamics	6.94	7.68	5.91	6.59
Process Focus	5.17	5.17	6.74	5.66
Linear Causality	6.26	6.45	6.00	6.28
Circular Causality	4.84	4.50	6.68	4.37
Content Focus	6.17	6.48	6.13	6.15
Systemic Dynamics	6.94	6.38	7.96	6.68

Ho7: Response Means by Program Accreditation

Vignette – Conceptual Dimension	CACREP	CACREP, APA	CACREP COAMFTE
Vignette 1			
Systemic Dynamics	5.15	5.50	5.38
Content Focus	5.93	6.12	4.62
Linear Causality	6.79	6.76	6.15
Process Focus	6.35	7.06	7.00
Individual Dynamics	4.22	5.00	2.62
Circular Causality	6.59	6.53	7.21
Vignette 2			
Individual Dynamics	3.81	2.59	3.00
Linear Causality	4.69	4.65	3.15
Content Focus	7.02	6.53	7.23
Circular Causality	7.59	7.35	7.46
Systemic Dynamics	6.32	6.88	7.92
Process Focus	6.56	7.06	8.21
Vignette 3			
Individual Dynamics	6.79	6.71	6.38
Process Focus	5.55	5.38	6.38
Linear Causality	6.23	6.50	6.08
Circular Causality	4.68	4.44	5.62
Content Focus	6.19	6.88	5.31
Systemic Dynamics	6.70	7.06	7.86

Ho8: Response Means for Primary Practica/Internships Setting

Vignette – Conceptual Dimension	MFC/T (N)	MHC (N)
Vignette 1		
Systemic Dynamics	5.84 (44)	5.05 (154)
Content Focus	5.50 (44)	5.97 (154)
Linear Causality	6.00 (44)	6.94 (150)
Process Focus	6.81 (43)	6.34 (151)
Individual Dynamics	3.14 (44)	4.52 (151)
Circular Causality	7.09 (44)	6.49 (154)
Vignette 2		
Individual Dynamics	3.18 (44)	3.80 (150)
Linear Causality	4.77 (44)	4.53 (150)
Content Focus	6.77 (44)	7.03 (150)
Circular Causality	7.64 (44)	7.54 (151)
Systemic Dynamics	6.75 (44)	6.41 (153)
Process Focus	7.32 (44)	6.57 (154)
Vignette 3		
Individual Dynamics	6.05 (43)	6.95 (151)
Process Focus	6.53 (43)	5.36 (150)
Linear Causality	5.88 (43)	6.38 (151)
Circular Causality	5.60 (43)	4.49 (147)
Content Focus	5.91 (43)	6.29 (151)
Systemic Dynamics	7.42 (43)	6.67 (150)

Ho8a: Response Means for Amount of Practica/Internships by Primary Setting

Vignette – Conceptual Dimension Primary Setting Type	1	2	3	4	5	6	7	8
Vignette 1								
Systemic Dynamics								
MFC/T	6.90	4.75	5.17	4.67	5.83	9.00	8.33	5.56
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(1)	(9)
MHC	5.44	4.61	4.09	4.92	5.16	2.00	7.00	4.50
(N)	(43)	(18)	(11)	(26)	(55)	(1)	(1)	(4)
Content Focus								
MFC/T	6.80	7.00	5.00	6.67	4.33	4.00	5.33	3.67
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.07	6.06	7.45	6.54	5.44	2.00	5.00	5.00
(N)	(43)	(18)	(11)	(26)	(54)	(1)	(1)	(4)
Linear Causality								
MFC/T	5.90	5.25	5.00	8.67	6.67	2.00	4.33	5.44
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.90	7.50	7.81	6.81	6.62	8.00	5.00	7.00
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Process Focus								
MFC/T	6.90	7.00	6.33	6.00	6.83	10.00	8.00	6.89
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.56	6.83	6.18	6.46	5.91	9.00	6.00	6.25
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Individual Dynamics								
MFC/T	4.50	4.00	2.33	3.67	2.67	1.00	2.33	2.00
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	4.51	5.38	4.09	5.50	4.19	3.00	4.00	2.50
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Circular Causality								
MFC/T	7.60	5.75	6.17	6.17	7.00	10.00	9.00	7.44
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.49	6.83	6.45	6.42	6.40	7.00	8.00	5.50
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)

Ho8a – Continued

Vignette – Conceptual Dimension Primary Setting Type	1	2	3	4	5	6	7	8
Vignette 2								
Individual Dynamics								
MFC/T	5.30	3.00	2.17	3.17	3.00	1.00	2.33	2.11
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	3.84	3.50	4.00	3.96	4.13	7.00	3.00	1.25
(N)	(43)	(18)	(11)	(25)	(53)	(1)	(1)	(4)
Linear Causality								
MFC/T	5.80	5.25	4.83	4.83	4.00	2.00	4.33	3.88
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	4.23	4.89	3.55	5.08	4.81	4.00	3.00	4.25
(N)	(43)	(18)	(11)	(25)	(53)	(1)	(1)	(4)
Content Focus								
MFC/T	7.50	8.00	6.17	6.67	8.17	3.00	4.33	5.78
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	7.05	6.72	7.36	7.54	6.81	6.00	6.00	7.00
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Circular Causality								
MFC/T	7.00	6.50	7.67	8.33	8.50	9.00	9.00	7.33
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	7.53	7.78	8.09	7.35	7.42	10.00	6.00	6.25
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Systemic Dynamics								
MFC/T	6.00	6.25	6.83	6.50	6.50	10.00	8.67	7.22
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.21	6.67	6.18	6.81	6.30	3.00	7.00	8.50
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)
Process Focus								
MFC/T	7.50	7.00	6.83	6.50	8.00	10.00	7.00	7.44
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.35	6.78	7.09	6.85	6.23	7.00	8.00	8.00
(N)	(43)	(18)	(11)	(26)	(53)	(1)	(1)	(4)

Ho8a – Continued

Vignette – Conceptual Dimension Primary Setting Type	1	2	3	4	5	6	7	8
Vignette 3								
Individual Dynamics								
MFC/T	6.80	4.50	7.33	6.50	5.83	4.00	4.00	4.89
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.41	7.47	7.91	6.46	7.23	8.00	7.00	6.25
(N)	(43)	(17)	(11)	(26)	(53)	(1)	(1)	(4)
Process Focus								
MFC/T	6.20	5.75	6.67	6.00	7.50	8.00	7.33	6.44
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	5.47	5.82	5.91	5.00	5.34	4.00	5.00	4.25
(N)	(43)	(17)	(11)	(26)	(53)	(1)	(1)	(4)
Linear Causality								
MFC/T	6.50	5.75	5.33	7.00	7.00	3.00	2.67	4.67
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.30	6.41	6.27	6.62	6.42	7.00	5.00	6.50
(N)	(43)	(17)	(11)	(26)	(53)	(1)	(1)	(4)
Circular Causality								
MFC/T	5.50	6.25	4.33	4.83	5.83	9.00	6.33	6.78
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	4.42	4.59	4.18	4.20	4.74	5.00	4.00	5.75
(N)	(43)	(17)	(11)	(25)	(53)	(1)	(1)	(4)
Content Focus								
MFC/T	7.10	6.50	5.33	6.00	5.17	2.00	5.00	5.67
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.30	5.76	7.73	7.42	5.68	8.00	5.00	5.50
(N)	(43)	(17)	(11)	(26)	(53)	(1)	(1)	(4)
Systemic Dynamics								
MFC/T	7.60	6.25	7.17	6.83	7.00	10.00	7.67	8.78
(N)	(10)	(4)	(6)	(6)	(6)	(1)	(3)	(9)
MHC	6.84	7.59	7.27	5.62	6.49	8.00	8.00	6.25
(N)	(43)	(17)	(11)	(26)	(53)	(1)	(1)	(4)

Ho9: Response Means for Professional Affiliation of Students' Respective Primary Supervisor/Educator/Instructor

Vignette – Conceptual Dimension	ACES-MFC/T	ACES-MHC	AMHCA	IAMFC	None
Vignette 1					
Systemic Dynamics	5.39	4.91	4.86	5.88	5.39
Content Focus	5.48	5.51	6.30	5.47	6.08
Linear Causality	7.91	6.43	7.22	6.00	6.44
Process Focus	6.41	6.02	6.19	7.00	6.75
Individual Dynamics	3.61	4.30	4.62	4.06	4.13
Circular Causality	6.79	6.15	6.38	7.94	6.67
Vignette 2					
Individual Dynamics	3.09	4.43	4.14	2.76	3.31
Linear Causality	4.00	5.04	4.78	4.36	4.42
Content Focus	6.52	6.94	7.32	6.47	7.06
Circular Causality	7.74	7.82	6.86	7.82	7.67
Systemic Dynamics	7.09	5.85	6.22	8.12	6.43
Process Focus	7.58	6.60	6.11	8.41	6.47
Vignette 3					
Individual Dynamics	6.67	7.02	7.14	5.47	6.68
Process Focus	5.59	5.70	5.26	6.06	5.63
Linear Causality	6.64	6.11	6.89	6.18	5.97
Circular Causality	5.33	4.89	4.49	5.88	4.32
Content Focus	5.50	6.15	6.80	6.24	6.18
Systemic Dynamics	6.96	6.89	6.66	7.65	6.62

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BIOGRAPHICAL SKETCH

Born in Louisville, Kentucky, and sharing the same date and time of her birth with her mother, Kelly M. Burch-Ragan graduated with honors from the University of South Carolina in 1996. She received the Bachelor of Arts in Interdisciplinary Studies with an emphasis in English and Psychology. In the process of obtaining her Master of Arts in Education degree in mental health counseling from Western Kentucky University in 1998, Kelly maintained a 4.0 G.P.A. Kelly also completed a post-graduate training program, specializing in marriage and family counseling/therapy, at Gainesville Family Institute in 2000. Kelly is licensed as both a Mental Health Counselor and Marriage and Family Therapist in the state of Florida. She also is a Nationally Certified Counselor.

Kelly grew up in Memphis, Tennessee, where she completed an International Baccalaureate high school program. During her formative years, Kelly was an elite (pre-Olympic) level gymnastics competitor, avidly trained in dance and voice, was invited to be a special guest on the New Mickey Mouse Club television show, traveled internationally to participate in gymnastics exhibitions and competitions, and was selected Tennessee's Jr. Miss in 1981. Kelly later traveled and entertained for the USO, performed as a singer/dancer at Opryland, USA and at other commercial venues, and eventually choreographed and directed her own musical reviews.

In the fall of1998, Kelly moved to Gainesville to attend the doctoral program in the Department of Counselor Education at the University of Florida. She was the recipient of a college fellowship (1998-2001). Throughout her graduate studies, Kelly

maintained an active academic agenda. In addition, she worked as a mental health counselor. She facilitated the development of counseling programs in two rural community settings, taught undergraduate courses at the University of Florida, published, and was active in professional associations. In 2001, Kelly married Rink R. Ragan. They share their home with Gizmo, a seven-year old Shih Tzu.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Larry C. Loesch, Chair
Professor of Counselor Education

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P. Joseph Wittmer
Distinguished Service Professor of
Counselor Education

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Peter Sherrard,
Associate Professor of Counselor
Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Cecil D. Mercer
Distinguished Service Professor of
Special Education